

# MIAMI SPRINGS ANIMAL HOSPITAL

## WELCOME

Welcome to MSAH. Thank you for giving us the opportunity to care for your pet. We will be happy to answer any questions you may have about your pet's health. Here at MSAH our mission is to provide your best friend with our very best loving, compassionate veterinary health and wellness care from before hello to beyond good-bye. To ensure the best care possible, please take the time to fill out this form.

**NOTE: DO NOT OPEN FILES FOR MINORS.**

**NO ABRIR EXPEDIENTES A MENORES DE EDAD.**

OWNER/DUEÑO \_\_\_\_\_  
LAST NAME-(APELLIDO) FIRST NAME - (NOMBRE) MIDDLE NAME  
ADDRESS/DIRECCION \_\_\_\_\_  
CITY/STATE ZIP CODE  
PHONE \_\_\_\_\_ EMERGENCY PHONE \_\_\_\_\_

SPOUSE or CO-Owner's NAME \_\_\_\_\_ PHONE \_\_\_\_\_

REFERRED BY \_\_\_\_\_

**Only for the clinic purposes: EMAIL ADDRESS**  
Please check here if you give us permission to put your pet's pictures on our Facebook. YES \_\_\_ NO \_\_\_

### PET No 1

### PET No 2

NAME/NOMBRE \_\_\_\_\_  
MICROCHIP # \_\_\_\_\_  
BIRTH DATE \_\_\_\_\_  
CAT \_\_\_ DOG \_\_\_ SEX \_\_\_\_\_  
BREED/RAZA \_\_\_\_\_  
COLOR \_\_\_\_\_  
NEUTERED?/ CASTRADO \_\_\_\_\_  
LAST DATE VACCINATION \_\_\_\_\_  
LAST DATE RABIES \_\_\_\_\_  
WHERE SHOTS OBTAINED? \_\_\_\_\_  
ALLERGIES \_\_\_\_\_  
LONG TERM PROBLEMS \_\_\_\_\_  
MEDICATIONS \_\_\_\_\_

NAME/NOMBRE \_\_\_\_\_  
MICROCHIP # \_\_\_\_\_  
BIRTH DATE \_\_\_\_\_  
CAT \_\_\_ DOG \_\_\_ SEX \_\_\_\_\_  
BREED/RAZA \_\_\_\_\_  
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WHERE SHOTS OBTAINED? \_\_\_\_\_  
ALLERGIES \_\_\_\_\_  
LONG TERM PROBLEMS \_\_\_\_\_  
MEDICATIONS \_\_\_\_\_

REASON FOR CALL: EXAM \_\_\_ DIARRHEA \_\_\_ COUGHING \_\_\_ SNEEZING \_\_\_ EATING PROBLEM \_\_\_  
VOMITING \_\_\_ OTHER \_\_\_\_\_

I hereby authorize the veterinarian and his/her assistants to examine, prescribe for, or treat, the above described pet (s). I assume responsibility for all charges incurred in the care of this animal. The nature of such services has been described to me, to my satisfaction, and while I expect all procedures to be done to the best abilities of the professional staff. I realize that there is no guarantee or warranty that can be ethically or professionally made regarding the results or cure. I understand that I will not receive a refund on any type of medication/and or vitamins. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment. I understand that Miami Springs Animal Hospital may be not present overnight; only during office hours.

SIGNATURE OF OWNER or AGENT \_\_\_\_\_ DATE \_\_\_\_\_