820 W HIND DRIVE #1221
HONOLULU, HI 96821
(808) 272-7000

WELCOME TO VETERINARY SPECIALTY GROUP

OWNER(S) INFORMATION

PRIMARY OWNER'S NAME _____, _____
(last) (first)

EMAIL ADDRESS _____

How did you hear about us? □ Referral: _____ □ Online: _____ □ Other: _____
(Name of person) (Google, Yelp) (Facebook, Instagram)

CO-OWNER/SPOUSE _____, _____
(last) (first)

MAILING ADDRESS _____
(street number) (city) (zip code)

PHONE NUMBER (PRIMARY) □ Landline □ Mobile □ Work (_____) _____-_____

CO-OWNER (SECONDARY) □ Landline □ Mobile □ Work (_____) _____-_____

BEST WAYS TO CONTACT YOU: □ Email □ Text □ Phone Call

PATIENT(S) INFORMATION

NAME	**SPECIES** (DOG, CAT, OTHER)	**BREED**	**MALE / FEMALE SPAYED/NEUTERED** (CIRCLE ONE)	**COLOR OR MARKINGS**	**DOB/AGE**	**INSURANCE?**
			M / F YES / NO			
			M / F YES / NO			

CURRENT VETERINARIAN/CLINIC: _____

Please read carefully and **sign** below:

1. I hereby grant permission for the release of any or all of the information contained in the medical record of my pet(s), listed above, to be given upon request to another veterinary practice or other party by fax, surface mail or by email. This release will remain in effect until otherwise notified by you in writing of desired changes.
2. I hereby consent to the use of my name, my pet's name, and photographs or videos of myself and/or my pet for any lawful purpose, including publicity, illustrations, website, and social media.
3. I hereby authorize the veterinarian to examine, prescribe for, and treat the above described pet. I assume responsibility for all charges incurred in the care of this animal. I also understand that **ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. WE DO NOT BILL.**

Signature of pet owner/guardian _____ Date _____