ROCKLIN RANCH
VETERINARY HOSPITAL

Owner's Name	**Last Name**	**First Name**	**Co-Owner**	
Address	**Street Name**	**City**	**State**	**Zip-Code**
Phone	**Home** ( )	**Cell** ( )	**Co-Owner** ( )	
Email:	**Owner's Email**	**Co-Owner Email**		

Owner Driver License #		Co-Owner Driver License #	
Date of Birth:		Date of Birth:	

Pet's Name:		**Breed:**		
☐ Canine ☐ Feline	Sex: ☐Male ☐Female	Altered: ☐Yes ☐No	Color:	Birth date:
Pet's Name:		**Breed:**		
☐ Canine ☐ Feline	Sex: ☐Male ☐Female	Altered: ☐Yes ☐No	Color:	Birth date:
Pet's Name:		**Breed:**		
☐ Canine ☐ Feline	Sex: ☐Male ☐Female	Altered: ☐Yes ☐No	Color:	Birth date:

Who can we thank for your business?

☐ Yellow Pages ☐ Hospital Sign ☐ Coupon ☐ Facebook ☐ Twitter	
☐ Client (Name):	☐ Website :
☐ Rescue Group:	☐ Veterinarian:

I hereby authorize Rocklin Ranch Veterinary Hospital to examine, prescribe for, treat, or perform surgery upon the above described pet(s). I also consent to the administration of such anesthetics as are necessary. Furthermore, I agree to pay fees for services rendered at the time the pet is discharged from the hospital or when service is otherwise terminated. I authorize the sharing of veterinary medical information between veterinarians or facilities for the purpose of diagnostics or treatment of my pet who is the subject of the medical records. I further understand that veterinary service may not be provided during the night time hours.

Signature of Owner **Date**