

455 Abernathy Rd NE, Atlanta, GA 30328  
Phone: 404-459-0903 Fax: 404-459-6462  
www.gvsvet.com

## Client Information & Standard Consent

Owner's Name \_\_\_\_\_

Spouse/Other \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Phone \_\_\_\_\_

Please list up to four phone numbers in order of how you can best be reached.

Name \_\_\_\_\_ Phone \_\_\_\_\_ ext. \_\_\_\_\_  Home  Work  Cell

Name \_\_\_\_\_ Phone \_\_\_\_\_ ext. \_\_\_\_\_  Home  Work  Cell

Name \_\_\_\_\_ Phone \_\_\_\_\_ ext. \_\_\_\_\_  Home  Work  Cell

Name \_\_\_\_\_ Phone \_\_\_\_\_ ext. \_\_\_\_\_  Home  Work  Cell

Primary Care Veterinarian \_\_\_\_\_ Clinic Name \_\_\_\_\_

Is your pet under the care of another veterinarian? \_\_\_\_\_

## Pet Information

Pet's Name \_\_\_\_\_  Dog  Cat

Breed \_\_\_\_\_ Age/DOB \_\_\_\_\_  Male  Female

Color \_\_\_\_\_ Spay/Neutered  Yes  No

What is the primary problem with your pet? \_\_\_\_\_

I am the owner of the above pet, or am acting as an agent for the owner and accept full financial responsibility. I give permission to proceed with a medical examination. An estimate will be provided for any medical and/ or surgical procedures deemed necessary by the doctor.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Driver's License Number \_\_\_\_\_ State \_\_\_\_\_

A copy of your driver's license is required for your patient records

Form(s) of Payment: Cash Personal Check ATM/Debit Visa MC DS AX CareCredit  
**PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED, THERE IS NO BILLING SERVICE**