Mission Animal Clinic
5915 Broadmoor, Mission, KS 66202
(913) 432-3341

Client Profile

Last Name:_____ First Name:_____

Address:_____ Home Phone:_____

City:_____ State:_____ Work Phone:_____

Zip:_____ County:_____ Cell Phone:_____ Spouse/Other:_____

E-mail Address: _____

Emergency Contact: _____ Emergency Phone: _____

Referral: Please let us know how you chose Mission Animal Clinic for you veterinary needs.

___Yellow Pages ___Other Advertisement ___Individual – Please supply us with the referring person's name:

Patient Profile

Pet's Name:_____ Sex:_____ Spayed/Neutered?_____

Birthday:_____ Breed:_____ Color:_____

Species (dog, cat, other):_____ Vaccinations Current?_____

If you pet is a cat, is it indoors or outdoors?_____ Both?_____

Prior Illness and/or surgery:_____

Is your pet currently on:

Heartworm preventative? Yes___ No___ If yes, what type?_____

Flea/Tick Control? Yes___ No___ If yes, what type?_____

Other medications? Yes___ No___ If yes, what type?_____

Please read the "Owner/Agent Authorization" statement on the back of this "Client Profile", then sign and date the form. If you have any questions prior to signing this form, please check with one of our staff members. Thank you for choosing Mission Animal Clinic for your veterinary needs.

Owner/Agent Authorization

I hereby authorize the doctors and staff of Mission Animal Clinic to administer treatment as is considered diagnostically and/or therapeutically necessary on the basis of findings obtained during the course of any evaluation. I hereby certify that I, being 18 years of age or over, assume financial responsibility for all charges incurred to the patient. I also understand that these charges will be paid at the time of release, and that a deposit may be necessary for treatment.

If I pay be check and the check is returned for any reason, I understand that I am still and immediately responsible for the face amount of the check plus all bank/associated fees. In addition, I will be required to pay by cash or by credit card for all future services or products purchased.

For security purposes, I also agree to provide proof of identity as requested, including at the time my account is set up as a new client and also if I pay by check or credit card.

I understand if I leave my pet(s) at Mission Animal Clinic for more than 30 days without prior arrangements being made and do not contact the doctors or staff with my intentions on picking up my pet, and/or the doctors or staff are unable to contact me by telephone or mail regarding when I will pick up my pet, it will be deemed I have abandoned my pet. Mission Animal Clinic will then assume ownership of my pet with full authority to place my pet up for adoption with a public agency or private individual, in which I will have no recourse.

Finally, I consent to the release of my pet(s)' medical information to other veterinary hospitals, boarding facilities, insurance companies, and pet insurance companies, as necessary.

Signature of Owner/Responsible Party:

_____ **Date**: _____

Professional fees are due at the time of service. We will gladly prepare a written estimate.

How do you plan to pay today? ___Cash ___Check ___Credit Card (Visa, Mastercard, Discover, or American Express)