

Kittel Family Veterinary Practice
8153 Elk Grove Blvd., Suite 30
Elk Grove, CA 95758
T (916) 714-5387
kfvp@kittelfamilyvet.com
www.kittelfamilyvet.com

1. Client Information:

First Name: _____ Middle Initial: _____ Last Name: _____

Driver's License: _____ Your Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

** We are a paper-light practice, using email regularly! Your email address will only be used within our business and pharmacy services to send you reminders for your pets and information from the vet.*

Primary Phone: () _____ circle: cell / home / work

Secondary Phone: () _____ circle: cell / home / work

2. Additional Contact: First Name: _____ Last Name: _____

Relationship to you: _____ Phone Number: () _____

3. Payment Information: Full payment is due at the time of service and a deposit may be needed prior to treatment depending on the services provided. We accept, cash, checks, and most major credit cards, including Care Credit. We do not bill or invoice our clients. There is a \$25.00 fee for any returned checks.

4. If you have CARE CREDIT & would like to keep your number on file, please enter the information below. Your personal information will be safe guarded and only used at your discretion.

Care Credit Card Number: _____ Full Name(s) on Card: _____

Note: Care Credit has a policy that card holders may no longer authorize someone else to use their card. Card holders must be present for EACH transaction & show 2 valid forms of ID. Please understand we CAN NOT make exceptions to this policy!

5. How did you hear about us? _____

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6. Release of Information: It is our policy to automatically share/release our patient's records to other animal-related businesses that ask for them. We extend this professional courtesy to groomers, boarding facilities, other vet offices, and specialists for the welfare of our patients. **If you would like to opt out of this policy, and would rather we call you for approval before releasing your pet's records, please initial here:** _____

7. Authorization of Ownership:

I authorize the following people to act as owner in my absence and on my behalf for any of my pets listed in my medical record at KFVP. The decisions these people are able to make include, but are not limited to, authorizing medical treatments/procedures required or recommended for my pet(s), authorizing the financial obligation that is a direct result of the treatment/procedure they authorized, consent or decline any DNR (Do Not Resuscitate) clause or euthanasia. **I understand that the people below must be over 18 years old** as they are acting on my behalf. I also understand that any costs accrued on my account are payable by me as I am the official owner of my pet(s) listed as patients at KFVP.

People approved to act on my behalf other than the additional contact already listed on page 1:

1. Name: _____ Phone Number: _____

2. Name: _____ Phone Number: _____

Owner's Signature: _____ Date: _____

8. Prior Veterinary Care:

Previous Veterinary Hospital/Doctor: _____

Previous Hospital's City & Phone #: _____

9. Do you have Pet Insurance, if so please list: _____