



VALLEY VIEW
ANIMAL HOSPITAL

Urgent Care Intake Form

Client Information

First Name: _____ Last Name: _____

Address: _____

Phone Number: _____ Email: _____

Spouse/Secondary Account Holder: _____

Phone Number: _____ Email: _____

Pet Information

Name: _____ Species: _____

Breed: _____ Color: _____

Sex: _____ Spayed or Neutered: _____ DOB/Age: _____

Allergies: _____

Name: _____ Species: _____

Breed: _____ Color: _____

Sex: _____ Spayed or Neutered: _____ DOB/Age: _____

Allergies: _____



Reason for visit: _____

Primary Veterinarian: _____

Phone Number: _____ Email: _____

As the owner, or authorized agent, of the above-named pet(s), I hereby consent and authorize Valley View Animal Hospital to prescribe, treat, or operate on this pet(s). I give Valley View Animal Hospital permission to give my pet's medical history to other veterinary professionals when necessary. I understand that all fees are due and payable upon the release of the patient. If the patient must be admitted for treatment, a deposit may be required at this time.

Printed Name

Date

Signature