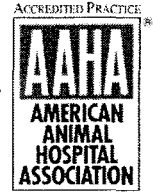


**Animal Medical Center of Cumming, Inc.**  
**Michael J. McLaughlin, D.V.M.**

Welcome to our clinic. Please fill out all of the information to the best of your knowledge. Payment is due when services are rendered unless other arrangements have been made and received in writing PRIOR to the time of your appointment. We do work by appointments, however walk-ins are welcome and will be seen, giving first consideration to appointments. Of course, emergencies always take priority. If you have any questions or problems regarding our services or policies, please feel free to discuss them with the Hospital Administrator or Dr. McLaughlin.



*Dedicated to  
Veterinary  
Excellence*

**OWNER INFORMATION:**

DATE \_\_\_\_\_ NAME \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

ADDRESS \_\_\_\_\_ SPOUSE'S NAME \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ COUNTY \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_ CELL PHONE SPOUSE \_\_\_\_\_

DRIVERS LICENSE NUMBER \_\_\_\_\_ STATE \_\_\_\_\_

WOULD YOU LIKE PET HEALTH INFORMATION BY E-MAIL? YES  NO

E-MAIL ADDRESS \_\_\_\_\_

HUSBAND'S PLACE OF BUSINESS \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_

WIFE'S PLACE OF BUSINESS \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_

**PET INFORMATION:**

NAME \_\_\_\_\_ BREED \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

HAS THIS ANIMAL BEEN NEUTERED \_\_\_\_\_ SPAYED \_\_\_\_\_

AGE \_\_\_\_\_ COLOR/MARKINGS \_\_\_\_\_

KNOWN MEDICAL CONDITIONS/ALLERGIES \_\_\_\_\_

LAST VACCINES GIVEN \_\_\_\_\_ DATE \_\_\_\_\_

WHERE \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

WOULD YOU LIKE REMINDERS SENT TO YOU WHEN VACCINES ARE DUE? YES  NO

OTHER VETERINARIANS WHO HAVE SEEN YOUR PET \_\_\_\_\_

DO YOU HAVE ANY OTHER PETS? YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, WHAT KIND? CAT \_\_\_\_\_ DOG \_\_\_\_\_ OTHER \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

I AGREE TO PAY FOR ANY AND ALL SERVICES RENDERED BY THE ANIMAL MEDICAL CENTER OF CUMMING, INC. AT THE TIME THE SERVICES ARE RENDERED. THIS CONSTITUTES THE ENTIRE AGREEMENT OF THE PARTIES AND NO CHANGES WILL BE VALID UNLESS RECEIVED, IN WRITING, AND SIGNED BY BOTH PARTIES.

SIGNATURE \_\_\_\_\_ WILL YOU PAY BY CASH, CHECK,  
VISA/MASTERCARD, CARE CREDIT. THERE WILL BE A \$30.00 FEE FOR ALL RETURNED CHECKS.