



PET ALLIES, INC. VACCINE & WELLNESS CLINIC - DOG FORM

Client Info: Date: \_\_\_\_\_

PAY BY: CASH/CHECK/DEBIT/MC/VISA/DISCOVER

Owner/Agent Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-Mail address: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Pet Info: Has this pet been vaccinated by Pet Allies, Inc. in the past?  Yes  No

Pet Name: \_\_\_\_\_  Male  Female | Pet Spayed/Neutered?  Yes  No

Breed: \_\_\_\_\_ Color: \_\_\_\_\_ Age: \_\_\_\_\_  Wks  Mo  Yrs

Within the LAST 2 WEEKS, has your pet had any of the following?

Sneezing  Coughing  Vomiting  Diarrhea  Other: Explain: \_\_\_\_\_

Has your pet ever had vaccinations?  Yes  No | Has your pet ever had a reaction to a vaccination?  Yes  No

If "Yes", please explain: \_\_\_\_\_

I hereby authorize the veterinarian of Pet Allies Spay/Neuter Clinic to perform indicated procedure(s). I understand that there may be risks involved in these procedures. I further understand that no guarantee, expressed or implied, has been given as to result(s) of the operation(s), procedure(s) or treatment(s) and I hereby release Pet Allies Spay/Neuter Clinic, its employees, volunteers and the attending veterinarian(s) from all liabilities and responsibilities, due to possible complications beyond their control. I understand that Pet Allies Spay/Neuter Clinic has the right to refuse service to any animal to whom treatment(s) is deemed a health risk. Pet Allies Spay/Neuter Clinic does not provide 24 hour care.

Owner/Agent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinic Use: \_\_\_\_\_ Weight: \_\_\_\_\_ Temp: \_\_\_\_\_ HR: \_\_\_\_\_ Resp: \_\_\_\_\_ Tech: \_\_\_\_\_

Exam:  Within Normal Limits Findings/Comments: \_\_\_\_\_

Table with 3 columns: SERVICES, QTY, AMOUNT. Rows include PHYSICAL EXAM, EAR CLEANING, ANAL GLAND EXPRESSION, NAIL TRIM, MICROCHIP.

Table with 3 columns: VACCINATIONS, QTY, AMOUNT. Rows include DHPP JUVENILE [ ] 1 YEAR [ ] vaccination, RABIES [ ] 1 YEAR [ ] 3 YEAR VACCINATION, BORDETELLA VACCINE, NAVAJO Co.or Show Low City LICENSE.

Table with 3 columns: SERVICES, QTY, AMOUNT. Rows include BIOMO DROPS 50mG/mL 30 ml, BIOMOX2 250 or 500 mg, CEPHALEXIN 250 or 500 mg, CLAVAMOX DROPS, CLAVAMOX 62.5mg TAB, CLAVAMOX 125MG TAB, CLAVAMOX 250mg TAB, CLAVAMOX 375MG, CLINDAMYCIN DROPS, EPI OTIC EAR CLEANSER, GENTIZOL OINTMENT, PENICILLIN INJECTION, NEMEX/STRONGID, BNP EYE OINTMENT.

Table with 4 columns: PROTICALL FOR DOGS, QTY, AMOUNT. Rows include \*\*\*\*\* 1 VIAL up to 33#, \*\*\*\*\* 2 VIALS 33 to 65#, \*\*\*\*\* 4 VIALS 66# and larger.

Table with 4 columns: DRONCIT 34 Tablets, QTY, AMOUNT. Rows include 5# and under, 6 - 10#, 11 - 15#, 16 - 30#, 31 - 45#, 46 - 60#, Over 60#.

Table with 4 columns: DRONCIT INJECTION, QTY, AMOUNT. Rows include 5 - 10#, 11 - 25#, 26 - 35#, 36 - 45#, 46 - 55#, 56 - 65#, 66 - 74#, 75# and up.