



DIXIE ANIMAL HOSPITAL  
— OVER 50 YEARS OF CARING —

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Fax (305) 238-9297  
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Website: www.dixieanimalhospital.com

## WELCOME

Thank you for giving us the opportunity to care for your pet(s).  
So that we may become better acquainted, please complete the following.

### OWNER INFORMATION:

Date: \_\_\_\_\_

Name: Ms. / Mrs. / Mr. / Dr. \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Driver's License: \_\_\_\_\_ SS# (Optional): \_\_\_\_\_

CELL Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

e-mail: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse/Significant Other: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_

How did you become aware of our clinic?  Drove By  Previous Client  Social Media  Google  Yelp  
 Manta  Yellow Pages  Personal Recommendation: \_\_\_\_\_

*(Whom may we thank?)*

### ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED

For your convenience, we accept Visa, MasterCard, Discover, American Express, CareCredit, Cash and Personal Checks. The undersigned agrees, as guarantor, that in consideration of the services to be rendered, he/she hereby individually obligates himself/herself to pay the account. I also understand that all fees are due at the time services are rendered unless an exception is made by the hospital director. Should the account be referred to an attorney for collection, I authorize attorney to obtain my credit report, and the undersigned shall pay reasonable attorney's fees and collection expenses. Any fees not paid in full within 30 days of services rendered accrue interest at 1.5% per month until the balance is paid.

To prevent the spread of infectious disease and parasites, all in-patients, out-patients, boarding pets and grooming pets MUST be current on ALL vaccinations and be free of parasites unless otherwise approved by one of the veterinarians. The undersigned agrees, as guarantor, that the patient below is current on ALL vaccinations or is to be required to have vaccinations administered by a veterinarian to avoid spread of infectious diseases and parasites.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Pet Name: \_\_\_\_\_ Age or DOB: \_\_\_\_\_  Dog  Cat

Breed: \_\_\_\_\_ Color(s): \_\_\_\_\_ Sex:  Male  Female

Is your pet spayed or neutered?  Yes  No • Is your pet up to date with their vaccinations?  Yes  No

Does your pet have a microchip?  Yes  No • Microchip #: \_\_\_\_\_

Medical Conditions/Concerns: \_\_\_\_\_

Previous Veterinarian/Clinic Name: \_\_\_\_\_

Michael J. Pegelow, D.V.M • Lara Sparks, D.V.M.

**TURN OVER**

#### For Internal Use Only:

Acct. # \_\_\_\_\_ VxHx: \_\_\_\_\_ DB: \_\_\_\_\_ Entered: \_\_\_\_\_ Typed: \_\_\_\_\_ WL: \_\_\_\_\_ Checked: \_\_\_\_\_ Ref.: \_\_\_\_\_



Date: \_\_\_\_\_

## Photography Release Form

I authorize Dixie Animal Hospital and the employees of Dixie Animal Hospital to use my pet's name, likeness, and any images taken with digital cameras or cellular devices, without charge, for promotional purposes in social media, advertising, news media, video publications, blog publications, web publications, or any other formats.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Pet's Name: \_\_\_\_\_

**For Internal Use Only:**

Acct. # \_\_\_\_\_ VxHx: \_\_\_\_\_ DB: \_\_\_\_\_ Entered: \_\_\_\_\_ Typed: \_\_\_\_\_ WL: \_\_\_\_\_ Checked: \_\_\_\_\_ Ref.: \_\_\_\_\_