Pet Wellness CENTER
Allergy and Dermatology

Patient Name: _____

Birth Date: _____ Breed: _____ M F neutered

Last Vaccine Administration Date: _____

Description: _____

Pet Parent Name: _____

Home Address:

Cell Phone: _____

Other Phone: _____

Email:

Primary Care Veterinarian:

Important Information:

I understand the Pet Wellness Center and its staff and Doctors are committed to providing the best possible care for my pet. I agree to provide all important information, allow my pet to be examined, and after discussion, consent to the agreed upon therapy for my pet.

I agree to allow the copying of my pet's medical records for medical and educational purposes. Your primary care veterinarian will be provided with copies of all relevant medical records (forms, summaries, results, and images) to allow them to continue the best possible care for your pet.

Pet Parent: _____ Date: _____

Dr. Keith A. Hnilica, DVM, MS, DACVD

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