



Zachary S. Coldiron, DVM 610 South Kelly, Suite Q Edmond, Oklahoma 73003 (405) 359-3340

Client Information

Date _____ Name _____
Last Name First Name Middle Initial Mr. Mrs. Ms.
Other _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Work Phone _____

Significant Others Name: _____ Cell Phone _____

Whom may we thank for referring you? _____

E-mail Address _____ D.L. # _____ State _____
If provided this will be for Stoneridge Animal Hospital use only! (Reminders, Specials, etc.)

Employer _____ Occupation _____

In case of emergency, who should we contact? _____ Phone _____

Pet Information

Pet's Name _____ Sex: M Neutered Unknown
F Spayed

Birthdate _____ Age _____ Breed _____ Color _____

Species: Avian Canine Feline Insectivore Lagamorph Marsupial Mustelid Porcine Primate Reptile Rodent

Describe the reason for your pet's visit _____

Payment Policy

We will gladly prepare a written estimate if you desire (please ask our doctor or receptionist). **ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.** In cases of extensive medical or surgical procedures where full payment may be difficult at discharge, we accept major credit cards or can establish a payment arrangement if approved in advance of the treatment. There will be a service charge for any check returned unpaid. Ask about financing available through CARE CREDIT!

To prevent the spread of infectious diseases, all hospitalized patients must be current on all vaccines and free from all internal and external parasites. The signature below authorizes this level of preventive care and the appropriate charges will be assessed in the discharge invoice.

Signature of Client Responsible for Pet(s) _____ Date _____

I will be paying with: _____ Cash _____ Check _____ Visa/MasterCard/Amex/Discover _____ Care Credit (if applicable)