



Dr. Scott Phearman  
Dr. Katrina Gustafson

**Client Account Information and Consent Form**

Owner Primary Name \_\_\_\_\_ Date \_\_\_\_\_  
Last First Middle Initial

Secondary Name/Relationship \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone(s) \_\_\_\_\_

Primary Email Address \_\_\_\_\_

Secondary Email Address \_\_\_\_\_

Primary Employer/Job Title \_\_\_\_\_ Work Phone \_\_\_\_\_

Secondary Employer/Job Title \_\_\_\_\_ Work Phone \_\_\_\_\_

**Pets in the household:**

Name	Species/Breed	Birthdate

**How did you become aware of our clinic?**

- Yellow Pages       Clinic Sign/Location       Commercial Referral       Newspaper       Internet
- Welcome Neighbor       Humane Society       Veterinary Referral       Other \_\_\_\_\_
- Friend/Relative: Whom may we thank? \_\_\_\_\_

1. I authorize pictures/videos of my pets/family to be used by Watertown Veterinary Clinic in any type of media, including website and social media platforms for education/promotional purposes. \_\_\_\_\_ (Initial to authorize)

2. I authorize the release of my pet's medical records and vaccination information to other veterinary clinics, boarding or training facilities when requested. \_\_\_\_\_ (Initial to authorize)

3. I understand that payment is required at the time of service. We accept cash, checks, Visa, Mastercard, Discover, American Express and CareCredit.

4. I understand that same day appointment and surgery cancellations and no show appointments may be subject to a cancellation or no show fee.

5. Please list any other person(s) not listed above that can make medical decisions for your pets.

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

**I have read and understand numbers 1-5 above. This consent remains in full force and effect unless I provide a written revocation of the consent.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_