

WELCOME TO COZY CAT VETERINARY HOSPITAL

3721 Lynn Rd. Suite #102 Raleigh, NC 27613
Phone: (919)571-9007 Fax: (919)571-9884



Dr. Colleen Wallace

Client Information:

Name: _____ Spouse/Partner: _____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Employer: _____ Work Phone: _____

Email: _____ Spouse/Partner Phone: _____

Date of birth: ____/____/____ (This information is required to dispense controlled medication)

Referred by: _____

Pet Information:

Name: _____ Age/DOB: _____

Breed: _____ Color/Markings: _____

Sex: _____ Spayed/Neutered: No Yes Microchipped: No Yes: # _____
(If you don't know your cat's microchip # we can scan him/her to find out what it is)

Vaccination/Medical History:

Rabies – Date Given: _____ 1 year 3 year

Distemper (FVRCP) – Date Given: _____ Feline Leukemia – Date Given: _____

Felv Test : _____ POS NEG FIV Test: _____ POS NEG

Does your cat have a history of any past illnesses or surgeries? If so, please explain: _____

Is your cat currently on any medication? If so, please let us know what kind: _____

I authorize Cozy Cat Veterinary Hospital to examine and provide service and/or treatment for the above described cat, and agree to be responsible for payment of any charges uncured. An estimate will be given as requested. I understand that the hospital policy is that payment is due in full when services are rendered and therefore agree to pay for all services at the time pet is discharged. I give permission for photos/images of my pet to be used on social media and public forums associated with our hospital.

Signature of Owner or Responsible Party: _____