Animal Dermatology South, LLC
Michael Canfield DVM, Diplomate ACVD
Phone: 727-807-3240
Fax: 727-848-2704
www.animaldermatologysouth.com
info@animaldermatology south.com

Print Email

NEW CLIENT INFORMATION

Name: _____ Spouse/Partner Name: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Number: _____ Spouse/Partner Cell _____

Cellular Number: _____ Spouse/Partner Work _____

Work Number: _____

E-Mail Address: _____

PET INFORMATION

Pet's Name: _____ Breed: _____ Color: _____

Age/Date of Birth: _____ Species: ☐ Dog ☐ Cat ☐ Other_____

Sex: ☐ Male ☐ Neutered Male ☐ Female ☐ Spayed Female

FAMILY VETERINARIAN

Hospital Name: _____

Phone Number: _____ Veterinarian's Name: _____

RELEASE OF INFORMATION FOR MEDIA OR WEBSITE PUBLICATION

After an explanation of its intended use, I authorize the staff at this veterinary practice to release portions of my pet's medical history and record, including personal recollections, radiographs, photographs, videotape images or other images.

I understand that this information may be used in the print media, on a brochure or on the website and Facebook page of this veterinary practice (Animal Dermatology South) and/or the website and Facebook Pages of hospitals affiliated with Animal Dermatology South for public education purposes and agree to its use in that manner.

I, the undersigned, am interested in educating the public about my pet's condition and medical care and authorize this veterinary practice or institution's faculty, clinicians, employees, students, and/or agents to use such materials for this purpose. I agree not to file any claim for revenue or lawsuit for damages against this veterinary practice with respect to the release of this information.

_____ Accept (Initial) _____ Decline (Initial)

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. The information I have provided is accurate to the best of my knowledge. I understand that all information I have provided will remain confidential. I may be asked to provide proper identification upon payment. I understand that I am financially responsible for all charges. All fees are due at the time services are rendered.

☐ Cash ☐ Debit card ☐ Visa/Mastercard ☐ Discover ☐ American Express ☐ Care Credit

_____ _____

Signature of client or authorized agent Date