Dr. James C. Clarkson, DVM

Dental Client Information

☐ ENTERED

Date_____

Name
(Mr., Mrs., Ms.)_____
(Last) (First) (Middle)
And/or
(Mr., Mrs., Ms.)_____
(Last) (First) (Middle)

Address_____

City_____**Zipcode**_____

Home Phone_____
Business/Emergency/Cellphone_____

Social Security Number and/or Driver's License Number_____
(REQUIRED BY THE STATE OF MICHIGAN FOR DISPENSING MEDICATION)

Email Address_____

Who referred you to our hospital, so that we may thank them?
_____
(Name of Veterinary Hospital or person who referred you)

Method of Payment (circle one) Cash Check Mastercard Discover Visa
Payment is expected at the time of service.
We do not bill unless prior arrangements have been made.

Pet Information:

Name of Pet_____**Species**_____

Breed_____**Color**_____

Sex_____**Spayed/Neutered?**_____**Age(Birthday)**_____

Additional Animals_____
_____

Your pet is being seen on a referral basis. Any other procedures and care including vaccinations, medications, and routine care, must be approved by your regular veterinarian, prior to being performed by a Westarbor doctor or technician. Thank you!