

VETERINARY SURGERY & ORTHOPEDICS

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Please fill out this Client Referral Information Form to expedite your check-in process; you may submit it electronically, fax it, or bring it with you to your appointment.

Client Referral Information

Client name:		Spouse/Partner name:		
Address:		City:	State:	Zip:
Phone:	Cell:	Work:	Email:	
Spouse/Partner Phone:				

Patient Information

Pet name:		Date of Birth:		
Species:	Breed:	Color:		
Sex:	Spayed/Neutered:	Weight:		

Primary Veterinarian

Dr.		Hospital:		
Address:		City:	State:	Zip:
Phone:		Fax:		

Hospital policy:

Estimates: An itemized estimate will be provided for recommended diagnostic and surgical procedures.

Payment: A deposit of one half of the estimate is required before any procedure is performed. The remaining balance must be paid in full upon release of your pet. Veterinary Surgery & Orthopedics cannot extend credit.

I understand that no guarantee can be made as to the results obtained from surgical treatment. Further, I assume financial responsibility for all charges incurred by the patient.

Client Signature: _____ **Date:** _____



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