



**CLINIC INFORMATION (print clearly)**

Name of Clinic: \_\_\_\_\_ Phone \_\_\_\_\_  
 Veterinarian \_\_\_\_\_ Email \_\_\_\_\_  
 Clinic address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

**BILLING INFORMATION (print clearly)**

*(required) 3 or 4 digit security*

Credit Card # \_\_\_\_\_ Exp. \_\_\_\_\_ Code \_\_\_\_\_  
 Signature \_\_\_\_\_ Phone \_\_\_\_\_  
 Who's card is this (*Please circle one*)      Clinic card      or      Client card  
 Billing address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

**SHIPPING INFORMATION (print clearly)**

Ship to: \_\_\_ CLINIC \_\_\_ OWNER \_\_\_  
 Ship by: FedEx Ground(\$10.50) \_\_\_ Overnight \_\_\_ 2-Day \_\_\_ 3-Day \_\_\_ International \_\_\_  
 Ship to address (if different than card) \_\_\_\_\_  
 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

**PET & OWNER INFORMATION (print clearly)**

Owner's Name: \_\_\_\_\_ Phone number: \_\_\_\_\_  
 Email address \_\_\_\_\_  
 Dog's Name: \_\_\_\_\_  
 Dog's Breed: \_\_\_\_\_ Age \_\_\_\_\_  
 Diagnosis \_\_\_\_\_  
 Does dog have:    \_\_\_ Cushing's Disease    \_\_\_ Addison's Disease    \_\_\_ Compromised auto-immune system  
                          \_\_\_ Severe skin allergies    \_\_\_ Long-term Prednisone therapy

**MEASUREMENTS**

1.) Measure around the dog's head, immediately in front of the ears \_\_\_\_\_  
 2.) Measure from immediately in front of the ears to the base of the neck \_\_\_\_\_