

# Patient/Client Information

**\*PLEASE PRINT\***

Thank you for giving us the opportunity to care for your pet. Please help us better meet your needs by taking a few moments to fill out **both sides** of this information sheet:

Owner's Name: \_\_\_\_\_ Spouse/Other: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Other: \_\_\_\_\_

E-mail address \_\_\_\_\_

How Would You Like To Be Reminded of Future Recommended Preventive Health Care Services For Your Pet?

Mail  E-Mail  Both Mail & E- Mail

Employer's Name & Address: \_\_\_\_\_

Spouse's/Other's Employer Name & Address: \_\_\_\_\_

At What Time \_\_\_\_\_ And At What Phone # \_\_\_\_\_ Is It Best to Call About Your Pet?

In Case of EMERGENCY, Call \_\_\_\_\_ At Phone # \_\_\_\_\_

**We will gladly prepare a written estimate if you so desire. Please ask a receptionist or doctor.** Professional fees are due at time services are rendered. If you wish to pay by check or credit card; please complete the following.

Bank Name: \_\_\_\_\_ Driver's License# \_\_\_\_\_

Preferred Method of Payment: ( ) Cash ( ) Check ( ) Credit Card

Are you eligible for our senior citizen discount (> 60 years)? ( ) Yes ( ) No

If Military: Rank: \_\_\_\_\_ P.C.S.: \_\_\_\_\_ E.T.S.: \_\_\_\_\_

How did you hear of our hospital?

( ) Individual, Someone We May Thank? \_\_\_\_\_

( ) Yellow Pages, or another telephone directory?

( ) Hospital Sign?

( ) Other, please state:

**DUE TO STATE LAW AND INSURANCE REQUIREMENTS, ALL DOGS & CATS MUST BE CURRENT ON RABIES VACCINATION. Vaccination can be updated at the time of your appointment if it is not current.**

I understand every effort will be made to achieve a successful outcome and to provide for all possible safety in hospital care and handling. I hereby authorize this hospital to receive, prescribe for, and treat the pet(s) listed on the reverse side and additional pets I present. Furthermore, I agree to pay fees for services rendered at the time the pet is discharged from the hospital or the service is otherwise terminated. I agree to pay for the reasonable costs of collection in the event that collection efforts become necessary. I understand that a service fee of \$25.00 will be assessed for each non-sufficient fund check and/or certified letter that must be sent. I understand that veterinary service is provided during nighttime hours as necessary in the judgment of the veterinarian in charge. Continuous presence of qualified personnel may not be provided. If I neglect to pick up my pet within 5 days of the discharge date and do not notify you within that time period, you may assume that my animal is abandoned and are hereby authorized to dispose of the animal, as you deem best and/or necessary.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**OVER**

# **Animal Medical History**



<b>Lyme</b>			
<b>Other Vaccines - Please Specify</b>			
<b>Rabies</b>			
<b>CATS: FVRCP (Infectious Diseases)</b>			
<b>FELV (Feline Leukemia)</b>			
<b>FIP (Feline Infectious Peritonitis)</b>			
<b>Rabies</b>			
<b>Other Vaccines - Please Specify</b>			
<b>Heartworm Test (Dogs)</b>			
<b>FELV Test or FIV Test ? (Cats)</b>			
<b>Fecal Test (Stool Exam for Worms)</b>			
<b>Dentistry (Approx Date Work was Done)</b>			
<b>Geriatric Health Screen (Approximate)</b>			

**Medical History - Prior Illness/Surgery:**

*Thank You!*

