



Patient / Client Information



Thank you for giving us this opportunity to care for your pet. Please help us meet your needs and the needs of your pet better by taking a moment to complete both sides of this information sheet.

CLIENT INFORMATION

DATE: _____ CLIENT ID: _____

OWNER: _____

ADDRESS: _____

HOME PHONE: _____ CELLULAR: _____ E-MAIL: _____

PLACE OF EMPLOYMENT: _____ PHONE: _____

ADDRESS: _____

SPOUSE/ CO-OWNER: _____

ADDRESS: _____

HOME PHONE: _____ CELLULAR: _____ E-MAIL: _____

PLACE OF EMPLOYMENT: _____ PHONE: _____

ADDRESS: _____

HOW DID YOU BECOME AWARE OF OUR CLINIC!

YELLOW PAGES HOSPITAL SIGN RADIO AAHA INTERNET OTHER _____

PERSONAL RECOMMENDTION WHOM MAY WE THANK? _____

PATIENT INFORMATION

	PET 1	PET 2	PET 3
NAME			
BREED			
DATE OF BIRTH			
COLOR			
SEX	FEMALE OR MALE	FEMALE OR MALE	FEMALE OR MALE
SPAYED OR NEUTERED?	YES OR NO	YES OR NO	YES OR NO
CURRENT DIET			

ANY PREVIOUS SERIOUS ILLNESS OR SURGERIES? _____

ANY ALLERGIES TO VACCINATIONS OR MEDICATIONS? _____

IS YOUR PET ON ANY MEDICATION? _____

PAYMENT

ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENEDEDERED.

WE WILL PREPARE A WRITTEN ESTIMATE IF YOU DESIRE. PLEASE ASK A MEMBER OF OUR HEALTH-CARE TEAM. FOR YOUR CONVENIENCE WE TAKE PERSONAL CHECKS, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, DEBIT AND CARE CREDIT.

THERE WILL BE A \$30.00 SERVICE CHARGE FOR ANY CHECK RETURNED UNPAID.

TO PREVENT THE SPREAD OF INFECTIOUS DISEASES, ALL HOSPITALIZED AND BOARDED PATIENTS MUST BE CURRENT ON ALL VACCINES AND FREE FROM INTERNAL AND EXTERNAL PARASITES. BY CLICKING ON THE SUBMIT BUTTON BELOW, YOU AUTHORIZE THIS LEVEL OF PREVENTIVE CARE AND YOU AGREE TO PAY THE APPROPRIATE CHARGES ASSESSED IN THE DISCHARGE INVOICE.

BY SUBMITTING THIS ONLINE FORM, I CERTIFY I AM THE OWNER OF THIS/THESE PET(S) AND I AGREE TO BE RESPONSIBLE FOR AUTHORIZING PROCEDURES AND/OR PAYING FOR SERVICES.