Client/Patient Information

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. State & Federal Law requires you must be 18 to complete this form.

Owner's Name: _____ **Spouse/Other:** _____

Owner's Social Security Number: _____ **Spouse/Other SSN**:_____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone #: _____ **Work Phone #:** _____

Employer's Name & Address: _____

If Military: Rank & Unit: _____ **P.C.S.** _____ **E.T.S.** _____

Spouse's/Other's Employer Name & Address: _____

When Is It Best to Call About Your Pet? At What Time: _____ **What Phone #:**_____

In Case of EMERGENCY, Call: **Phone #** _____ **Cell Phone #** _____ **Pager #** _____

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 ☐ Veterinary Pet Insurance

Name of Previous / Current Veterinarian: _____

How did you hear of our hospital? _____

DUE TO STATE LAW AND INSURANCE REQUIREMENTS, ***as well as helping us control & prevent the spread of infectious diseases within our hospital, ALL hospitalized and boarded pets must be current or updated at the time of admission for all vaccinations recommended in our preventive health care program against infectious diseases.***

DISCLAIMER, WAIVER, and BLANKET PERMISSION FOR TREATMENT

I understand every effort will be made to achieve a successful outcome and to provide for all possible safety for my pet, I hereby authorize this hospital to receive, prescribe for, treat and/or perform surgery upon the pet(s) listed below or on the reverse side as well as any additional pets I present in the future until otherwise directed in writing. 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 $30.00 will be assessed for each non-sufficient funds check and a $25.00 certified letter that must be sent. All accounts unpaid after 30 days receive a $6.85 Billing Charge each month and a late charge computed at a periodic rate of 1.50% per month, which is an annual percentage rate of 18.00% with a minimum monthly charge of $1.00. 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 the pet is abandoned and you are hereby authorized to dispose of the pet as you deem best and/or necessary.

Signature_____ Date _____Witness _____
(Owner/Agent) Admitting Staff Member

Pet's Name_____ Breed_____ Sex_____ Age_____

Pet's Color _____ Is your pet spayed/neutered? [ ] Yes [ ] No

What is the purpose of today's visit? **[ ] Sick Pet [ ] Well Care Visit**

Vaccination History: