



INFORMATION FORM

Date ____/____/____

CLIENT INFORMATION

Title (check one): Mr. Mrs. Ms. Miss Dr.

Owner(s) Name _____
LAST FIRST M.I.

Spouse/Other _____

Home Address _____
STREET APT # CITY ZIP

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

E-mail address _____

PET INFORMATION

Pet Name _____ Dog Cat Other _____ Breed _____

Sex _____ Spay/Neutered Y N D.O.B. _____ Color _____

Is your pet current on vaccinations? Y N

Primary Veterinarian _____ Phone _____

Hospital Name _____

Referring Veterinarian _____ Phone _____

Hospital Name _____

I would like my pet's records faxed to (check all that apply):

Primary Veterinarian _____ Referring Veterinarian _____ Other _____

Does your pet exhibit any behavioral problems that may pose a risk to our doctors or technical staff?

Y N If yes, please explain _____

Driver's License No. _____ Expires _____ State _____

I understand that I am financially responsible for all charges for services rendered. I agree in the event of non-payment to bear the costs of finance charges at the rate of 1% per month, the costs of all collection and/or court costs and legal fees, should this be required.

Signature of responsible owner _____
or agent (18 years or older)