CLIENT / PATIENT INFORMATION

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

Date: _____ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. ☐ Dr. ☐

Owner's Last Name: _____ First Name:_____ Spouse:_____

Address: _____ Apt. #_____ City:_____ Postal Code: _____

E-mail address: _____

Home Phone:_____ Work Phone: _____ Cell Phone: _____

In case of EMERGENCY please call:_____ at # _____

How did you find out about our hospital?

Yellow pages ☐ Hospital sign ☐ Client ☐ Staff ☐ Location ☐ Other ☐

Who may we thank for your referral? _____

PATIENT INFORMATION

PET'S NAME	BREED	SEX M, MN F, FS	COLOR	BIRTH DATE	DATE OF VACCINATION

ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED, OR UPON THE RELEASE OF THE PATIENT.

Please indicate the form of payment you prefer.

Cash ☐ Interac ☐ Visa ☐ MasterCard ☐ AMEX ☐

***** NO CHEQUES ACCEPTED *****

Do you wish to be a client of our hospital?

Yes ☐ No ☐ _____

Signature

TO PREVENT THE SPREAD OF INFECTIOUS DISEASES AND PARASITES, HOSPITALIZED AND BOARDED ANIMALS MUST BE CURRENT ON ALL VACCINES AND FREE OF INTERNAL AND EXTERNAL PARASITES.

PLEASE KEEP YOUR PET RESTRAINED BY LEASH OR CARRIER AT ALL TIMES. THANK YOU.