

CLIENT INFORMATION

OWNER _____ SPOUSE/CO-OWNER _____
Drivers License # _____ Drivers License # _____
Home Address _____
street apt. # state zip
Home Phone _____ Home Phone _____
Cellular or Mobile Phone _____ Cellular or Mobile Phone _____
Owner Occupation _____ Spouse/Co-owner Occupation _____
Owner Employer _____ Spouse/Co-owner Employer _____
(If self employed, please list name of business)
Owner Work Phone _____ Spouse/Co-owner Work Phone _____
Children (first name and age) _____
How did you choose our hospital?
[] Yellow Pages [] Clinic Sign [] Previous Client [] Location
Individual we may thank for recommending us: _____
E-mail Address: _____

PET INFORMATION

Pet Name _____ Pet Name _____
[] Dog [] Cat [] other [] Dog [] Cat [] other
[] Male [] Female [] Spayed/Neutered [] Male [] Female [] Spayed/Neutered
Breed _____ Breed _____
Color _____ Color _____
Age _____ Date of Birth _____ Age _____ Date of Birth _____
Previous Vaccines _____ Previous Vaccines _____
Date of Vaccines _____ Date of Vaccines _____
Allergies? _____ Allergies? _____
Serious Illnesses _____ Serious Illnesses _____
Brand of Pet Food _____ Brand of Pet Food _____
Behavior Problems _____ Behavior Problems _____

PAYMENT INFORMATION

Payment is expected at the time services are rendered. The Doctor or Receptionist will gladly prepare a written estimate for you prior to treating your animal.

Please indicate your preferred payment method
[] Cash [] Check [] Visa/MasterCard

I hereby authorize Companions Animal Hospital, LLC to provide diagnostic and treatment procedures for my pet. I understand that I am responsible for all charges incurred in this care. I also understand that these fees are to be paid at the time services are rendered and that a deposit may be required for certain medical or surgical treatments.

Owner/Owner's agent _____ Date _____