Compassion
ANIMAL HOSPITAL

Thank you for giving us the opportunity to care for your pet(s). So that we may become better acquainted, please complete the following:

CLIENT INFORMATION Date _____

Name _____ Spouse's Name _____

Mailing Address _____ City _____ State _____ Zip _____

Physical Address _____ City _____ State _____ Zip _____

Phone _____ Work Phone _____ Spouse's Work Phone _____

Place of Employment _____ Best time to reach you _____

Driver's License # _____ Social Security # _____

Email Address: _____

How did you become aware of our hospital? ❑ Drove by ❑ Yellow Pages ❑ Previous Client ❑ Newspaper ❑ Other _____

Personal Recommendation (whom may we thank?) _____

PATIENT INFORMATION *(Please complete information for each pet)*

	PET #1	PET #2	PET #3
Name			
Breed			
Date of Birth			
Length of Time Owned			
Color			
Sex: Spayed or Neutered			
VACCINATION HISTORY - DOG Rabies			
DHLP Parvo Corona			
Bordetella			
Last Fecal Exam (Worms)			
Heartworm Test / Prevention			
VACCINATION HISTORY - CAT Rabies			
Dist-Rhino Chlamydia			
Feline Leukemia			
Last Fecal Exam (Worms)			

Our pet(s) is: ❑ A member of our family ❑ Just a pet

Any previous serious illnesses or surgeries? _____

Any allergies to vaccinations or medications? _____

Is your pet on any special diets or medications? _____

I understand that any unpaid bill past 30 days will be subject to an 18% interest charge. I will also be responsible for an additional 50% collection fee if a collection service is required

AUTHORIZATION FOR TREATMENT

I authorize and direct Compassion Animal Hospital, Dr. Cooper or his associate, to treat the above mentioned animal or any additional animals I own. I UNDERSTAND THAT FEES WILL BE PAID IN FULL AT THE TIME SERVICES ARE RENDERED.

Please indicate choice of payment: ❑ Cash ❑ Check ❑ Visa/Mastercard

_____

Signature of Owner or Responsible Agent