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

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Signature of Owner or Responsible Agent