

Welcome to Community Animal Hospital!

Owner Information

Name: _____
Street Address: _____
City, State, Zip: _____
Home Phone: _____
Work Place : _____
Work Phone: _____
Additional Phone: _____

Co-Owner: _____
Home Phone: _____
Work Place : _____
Work Phone: _____
Additional Phone: _____

Referred By: _____

In the event that we cannot reach you, please provide us with the name and phone number of a person who could contact you and is authorized to make decisions and financial arrangements for the health and well-being for your pet.

Name _____ Phone _____ Alt. Phone _____

Patient Information

Pet's Name: _____ Species: _____ Weight: _____
Birth Date/Age: _____ Breed: _____ Microchip: _____
Sex: _____ Neutered? _____ Color/Markings: _____ Other ID: _____

Pet acquired where? _____ When? _____

When and where was patient's last veterinary exam? _____

Last rabies vaccination? _____

May we contact them for prior medical records? Yes / No (circle one)

List any long term problems: _____

Is your pet on any medications? _____

Does your pet travel, vacation, board, or groom often? _____

List names and types of other pets at home. _____

Authorization

I authorize the veterinarian and/or the staff of Community Animal Hospital to examine, prescribe, and treat the above described pet. I assume responsibility for all charges incurred in the care and treatment of this animal. I also understand that these charges will be paid in full at the time of treatment or release of this animal, as determined by the hospital staff. I also understand that a deposit may be required in advance of certain procedures.

Owner or Agent Signature _____ Date _____

Method of Payment (circle one): Cash MC/Visa Discover ATM (We do not accept checks on new accounts.)