Welcome to Community Animal Hospital!

Owner Information

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

Co-Owner: _____
Home Phone: _____
Cell Phone: _____
Work Place: _____
Work Phone: _____
Email: _____

***Preferred form of contact. Please circle all that apply:**
Home Number Cell Number Text Email

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: _____
Birth Date/Age: _____
Sex: _____Neutered? ___

Species: _____
Breed: _____
Color/Markings: _____

Weight: _____
Microchip: _____
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.)