Companion Animal Hospital

Welcome to Companion Animal Hospital. So we may provide you with exceptional service, please share information about you and your pet(s). Companion Animal Hospital acknowledges the importance of the human animal bond, knowing that the majority of pets we see are thought of as members of the family. We are animal lovers, progressive thinkers, and educators. We hold high standards for our practice and ourselves.

Client Information:

First Name _____ Last Name _____

Spouse first name _____ Spouse last name _____

Address _____ City _____ State _____

Zip _____ County _____

Home Phone _____ Cell Phone _____ Work Phone _____

Spouse Cell _____ Spouse Work Phone _____ Ext _____

Email address _____

Drivers Licnese # _____ License Exp: _____

What is your preferred method of contact? _____

Patient Information:

Pet's Name _____ Sex: Male ___ Female ___

Species: Dog ____ Cat ____ Other ____ Spayed/Neutered? Yes ____ No ____

Pet's date of Birth: _____ or Age: _____ Breed: _____

Color: _____

Has your pet been to another veterinarian? Yes / No If so, where: _____

How did you become aware of Companion Animal Hospital?

___ Sign ___Facebook ___Weis Cart ___Google ___Yellowbook ___Radio ___Other

___Our Website ___Friend Whom may we thank?_____

All fees are due at the time services are rendered. For your convience, we accept cash, check, Mastercard, Visa, Discover, American Express, and Care Credit.

If you must cancel an appointment, we ask for 24 hours' notice. If cancelling a surgical appointment, we ask for 48 hours' notice.

For your protection, and that of others, pets should be properly restrained by a leash or carrier upon arrival.

Authorization for examination, treatment, photos, and assumption of financial responsibility

I herby authorize the veterinarian to examine, prescribe for and/or treat the described pet(s). I assume responsibility for all charges incurred in the care of my animal(s). I also understand that these charges will be paid at the time of release and that a deposit will be required for hospitilization or surgical treatment. Any photographs taken of my pet along with my name may be used in electronic or printed material for publicity or advertising purposes.

Owner/Agent Signature: _____ Date: _____ Staff Initials: _____

Pet #2			
Pet's Name:			
Date of Birth or Age:			
Species:	Dog ____	Cat ____	Other ____
Breed:			
Sex:	Male ___	Female ___	
Spayed/Neutered?	Yes ____	No ____	
Color/Markings:			
Vaccinations were last given by (clinic name):			
Allergies or Long-term Medical Problems:			

Pet #3			
Pet's Name:			
Date of Birth or Age:			
Species:	Dog ____	Cat ____	Other ____
Breed:			
Sex:	Male ___	Female ___	
Spayed/Neutered?	Yes ____	No ____	
Color/Markings:			
Vaccinations were last given by (clinic name):			
Allergies or Long-term Medical Problems:			

Pet #4			
Pet's Name:			
Date of Birth or Age:			
Species:	Dog ____	Cat ____	Other ____
Breed:			
Sex:	Male ___	Female ___	
Spayed/Neutered?	Yes ____	No ____	
Color/Markings:			
Vaccinations were last given by (clinic name):			
Allergies or Long-term Medical Problems:			

Pet #5			
Pet's Name:			
Date of Birth or Age:			
Species:	Dog ____	Cat ____	Other ____
Breed:			
Sex:	Male ___	Female ___	
Spayed/Neutered?	Yes ____	No ____	
Color/Markings:			
Vaccinations were last given by (clinic name):			
Allergies or Long-term Medical Problems:			

Pet #6			
Pet's Name:			
Date of Birth or Age:			
Species:	Dog ____	Cat ____	Other ____
Breed:			
Sex:	Male ___	Female ___	
Spayed/Neutered?	Yes ____	No ____	
Color/Markings:			
Vaccinations were last given by (clinic name):			
Allergies or Long-term Medical Problems:			

Pet #7			
Pet's Name:			
Date of Birth or Age:			
Species:	Dog ____	Cat ____	Other ____
Breed:			
Sex:	Male ___	Female ___	
Spayed/Neutered?	Yes ____	No ____	
Color/Markings:			
Vaccinations were last given by (clinic name):			
Allergies or Long-term Medical Problems:			