



## Patient/Client Information Sheet

\*\* Accepted forms of payment are MasterCard, Visa, American Express, Care Credit, and cash \*\*

We will gladly provide you with a written estimate if you desire. Professional fees are payable in full at the time services are rendered. If another payment agreement has been made prior to treatment and is not kept as arranged, then authoritative action will take place immediately.

### **Owner's Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Spouse: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Mobile (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ Expires: \_\_\_\_\_ / \_\_\_\_\_ D.O.B: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Credit Card Company: \_\_\_\_\_ Number: \_\_\_\_\_ Exp: \_\_\_\_ / \_\_\_\_

\*\* to be used for phone payment only with client's permission \*\*

### **Patient's Information:**

Mark one: Dog  Cat  Bird  Rabbit  Reptile  Pig  Goat  Pocket Pet

Pet #1 Name: \_\_\_\_\_

Pet #2 Name: \_\_\_\_\_

Breed: \_\_\_\_\_

Breed: \_\_\_\_\_

Color: \_\_\_\_\_

Color: \_\_\_\_\_

Age or D.O.B.: \_\_\_\_\_

Age or D.O.B.: \_\_\_\_\_

Sex: \_\_\_\_\_ Altered: \_\_\_\_\_

Sex: \_\_\_\_\_ Altered: \_\_\_\_\_

Is your pet(s) currently on any medications? \_\_\_\_\_

Does your pet(s) have any drug and/or food allergies? \_\_\_\_\_

How did you hear about our hospital? \_\_\_\_\_

I assume all financial responsibilities for all charges incurred at Angel's Care Animal Hospital. I consent to medical, surgical treatment, and veterinary care of my pet s deemed necessary by the doctor and staff. I consent to the release of medical information, and authorize direct payment to Dr. Bill Hat at Angel's Care Animal Hospital.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_