



Patient/Client Information Form

Tell us about you!

Today's Date: _____

*Your Name _____ *Spouse _____

*Address _____

*City _____ *State _____ *Zip _____

*Home Phone _____ Business Phone _____

Cell Phone _____ Emergency Phone _____

Email Address _____

Drivers License # _____ Social Security # _____

Place of Employment _____ Spouse's Employment _____

*How did you hear about us?

- An Individual we may thank _____
- Our Hospital sign - HOS
- Our Yellow Page Ad - YEL
- Our Web Site or the Internet - WEB
- Another Veterinary Hospital or organization _____
- Other _____

Tell us about your pet!

*Pet's Name _____

*Species _____ *Breed _____ *Date of Birth _____

*Sex _____ Microchip # _____

*Color and Markings _____

*When was your pet vaccinated last? _____

Official Use Only
Vaccine Reminder Set Date: ____/____/____

*Does your pet have any medical problems? _____

*Does your pet have any allergies? _____

Hospital consent for treatment and payment

I hereby authorize Shallowford Animal Hospital, Inc. to examine, prescribe for and treat my pet(s). I also consent to the administration of such anesthetics as are necessary. I understand that Shallowford Animal Hospital, Inc. cannot guarantee success of any treatment provided for my pet, and that I am responsible for payment of all charges incurred regardless of the results, at the time my pet(s) are discharged from the hospital or when treatment is otherwise terminated. Deposits for services may be required prior to treatment. I further agree to pay a late charge of 0.8% per month, or the maximum allowable by law, whichever is lower, plus a \$5.00 monthly billing fee, in the event that I do not pay the final balance on my bill within 30 days of receipt. I agree that if I pay any portion of my account by check, and my check is returned by the bank for any reason, I will pay Shallowford Animal Hospital, Inc. \$35.00 for each check so returned. I also agree that in the event that my account is referred for collection for non-payment, that I will pay Shallowford Animal Hospital, Inc., a reasonable attorney's fee for collection of my account. Payment is expected when services are rendered, unless other arrangements are made in advance.

Signature of owner or responsible agent: _____ Date: _____