CLIENT INFORMATION FORM

Pet Name: _____ Dog / Cat Male/Female Spayed or Neutered? Yes/ No
Breed: _____ Colors: _____
Date of Birth: _____ Date of Last Vaccines: _____

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Previous Veterinarian: Would like us to call to get a copy of the medical records faxed to our hospital? YES / NO

Client Full Name / Owner #1: _____

Co-Owner or Spouse Name: _____
Home Street Address: _____
City: _____ State: _____ Zip: _____
Driver's License # _____ exp: _____

Contact Numbers: Home: _____
Cell #1: _____ Work #1: _____
Cell #2: _____ Work #2: _____
Email Address: _____
Is it ok to text your cell in case of emergency? Yes / No
Is it ok to send you emails for reminders for vaccines and health alerts in our newsletter? Y / N

Employer Name: _____
Employer Address: _____

Spouse/Co-owner Employer Name: _____
Employer Address: _____

Emergency Contact Person and Phone #: _____
In case of emergency and you are not available, who may we call to authorize treatment for your pet.

How did you become aware of our hospital?
- □ Shadowridge Vet Hospital Webpage -
- □ Internet search - Please let us know which search engine or website: _____
- □ Facebook
- □ Yellow pages
- □ SPCA or shelter referral
- □ Drove by facility
- □ Personal Recommendation (who may we thank? _____)

Authorization for us to see your pet:
I, the undersigned, and owner or authorized agent of the above mentioned pets do hereby authorize Shadowridge Veterinary Hospital to perform such examinations, diagnostic tests and treatments as necessary and authorized by me whether verbally or in writing. I further agree to be financially responsible for all costs for such procedures and treatments. I understand that full payment is due at the time services are rendered. I understand that abandonment of animals does not relieve me of financial obligation. Failure to pay bills at time of service may result in billing and finance charges and/or all costs associated with collection fees incurred.

Signature: _____ **Date:** _____