WELCOME TO THE CLINIC WHERE WE PROVIDE "EXCEPTIONAL CARE FOR EXCEPTIONAL PETS!"

CLIENT AND PET INFORMATION FORM

Today's Date ______________

Owner's Name ________________________________ Phone (___)_______________

Co-Owner ____________________________________ Phone (___)_______________

Address ____ Apt ____________

City __________________________ State ______________ Zip _____________________

E-mail address _____________________ Driver's License # ______________ STATE ___ EXP. ___

How did you learn of our clinic? ☐ Sign ☐ Internet ☐ Recommendation __________ ☐ Other

DAYTIME PHONE NUMBERS ARE VERY IMPORTANT TO US! Work _________ Cell __________

Social Media Release: I grant Hope Animal Medical Center (HAMC) and its employees the right to take photographs of me and/or my pet, and to copyright, use and publish the same in print and/or electronically. I agree that Hope Animal Medical Center may use such photographs of me and/or my pet with or without my name and for any lawful purpose, including, for example, such purposes as publicity, illustration, advertising, and Web content.

☐ HAMC may take photos of me and/or my pet ☐ HAMC may NOT take photos of me and/or my pet

Name of Pet: ____________________________________ Male / Female (circle one)

Dog / Cat / Rabbit / Bird / Other: ___________________ Neutered / Spayed

Breed __________________________________ Color ________________________

Microchip Number: ____

Indoor ______ Outdoor _______ Birth Date/Age ____________

Vaccination History (provide dates if known) Previous Veterinarian _________________________

Distemper ___________ Rabies ____________ Leukemia ____________ FRCP___________

Bordetella ____________ Heartworm Check ____________ (see reverse side for additional pets)

**** PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED ****
We accept cash, checks, Visa, Mastercard, Discover, American Express and Care Credit.
I, the undersigned owner or authorized agent of the above admitted patient, hereby authorize the doctors and staff of Hope Animal Medical Center to administer such treatment as is necessary and to perform procedures therapeutically and/or diagnostically. I further understand that no guarantee of successful treatment is made. I also assume financial responsibility for all charges incurred, and agree to pay all such charges at the time of release.

Signature of owner/agent___________________________ Date _____________

Name of Pet: ____ Male / Female (circle one)

Dog / Cat / Rabbit / Bird / Other: _____________________ Neutered / Spayed

Breed ______________________________________ Color __________________________

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