

Patient/Client Information

Thank you for giving us the opportunity to care for your cat(s). Please help us better meet your needs by taking a few moments to fill out both pages of this information sheet.

Mr. _____

Mrs. _____ Spouse/Other: _____

Ms. (last name), (first name)

Dr. _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Spouse Work #: _____

Cell Phone #: _____ Owner's Drivers License Number: _____

e-mail address: _____

Employer's Name & Address: _____

Spouse's/Other's Employer Name & Address: _____

In Case of EMERGENCY:

Alternate Contact: _____ Relation: _____ Phone _____

Professional fees are due at time services are rendered. Current Drivers license or California identification required for payments other than cash.

Preferred Method of Payment: Cash Check Credit Card ATM

Do you carry Pet Insurance? No Yes If yes: Carrier: _____

How did you hear of our hospital?

Individual, Someone We May Thank? _____

Yellow Pages, or other telephone directory?

Hospital Sign? Mail? Newspaper? Internet?

Other? Please State: _____

How Would You Like To Be Reminded of Future Recommended Preventive Health Care Services For Your Cats?

e-mail Mail Both Mail & e-mail

To help prevent the spread of infectious diseases, hospitalized patients must be current on FVRCP and Rabies. Vaccinations can be updated at the time of your appointment if they are not current.

I understand every effort will be made to achieve a successful outcome and to provide for all possible safety in hospital care and handling. I hereby authorize this hospital to receive, prescribe for, treat or perform surgery upon the pet(s) listed on the reverse side and additional pets I present. Furthermore, I agree to pay fees for services rendered at the time the pet is discharged from the hospital or the service is otherwise terminated. I agree to pay for the reasonable costs of collection in the event that collection efforts become necessary. I understand that a service fee of \$20.00 will be assessed for each non-sufficient fund check and/or certified letter that must be sent. All accounts unpaid after 30 days receive a \$5.00 Billing Charge each month and a late charge computed at a periodic rate of 1.50% per month, which is an annual percentage rate of 18.00% with a minimum monthly charge of \$1.00. I understand that veterinary service is provided during the nighttime hours as necessary in the judgment of the veterinarian in charge and that continuous presence of qualified personnel may not be provided.

Signature _____ Date _____

