

CLIENT INFORMATION

NAME _____ DATE _____
HOME ADDRESS _____ HOME PHONE _____
CITY _____ STATE _____ ZIP _____ CELL PHONE _____
DRIVER'S LICENSE NO. _____ EXP. DATE _____
SOCIAL SECURITY NO. (Optional) _____
EMPLOYER _____ OCCUPATION _____
BUSINESS ADDRESS _____ BUSINESS PHONE _____
SPOUSE OR CO-OWNER _____ EMPLOYER _____
OCCUPATION _____ SPOUSE/CO-OWNER'S WORK PHONE _____
IF NECESSARY, MAY WE CALL YOU AT WORK? _____
ARE THERE CHILDREN IN THE HOUSE? _____ NO _____ YES HOW MANY? _____ AGES? _____
IS THIS YOUR FIRST VISIT TO THIS HOSPITAL? _____ IF CHANGING PET CARE FACILITIES, WHAT IS THE
REASON FOR YOUR CHANGE? _____
HOW DID YOU LEARN OF THIS PRACTICE? _____ YELLOW PAGES _____ HOSPITAL SIGN _____ WEBSITE
_____ PERSONAL RECOMMENDATION - WHO MAY WE THANK? _____
IF YOU WOULD LIKE TO BE ADDED TO OUR ELECTRONIC MAILING LIST TO RECEIVE THE LATEST NEWS AND INFORMATION
FROM US PLEASE SHARE YOUR E-MAIL ADDRESS: _____

PATIENT INFORMATION

PET'S NAME _____ BREED _____ COLOR _____
SEX _____ SPAYED/NEUTERED? YES / NO AGE _____ DATE OF BIRTH _____
WHERE DID YOU ACQUIRE PET? (ie. BREEDER, SHELTER, PET SHOP, OTHER) _____
DATE OF PET'S LAST VACCINATIONS _____
NAME OF HOSPITAL/CLINIC WHERE GIVEN: _____ PHONE _____
DO WE HAVE YOUR PERMISSION TO CONTACT YOUR PREVIOUS VETERINARIAN FOR YOUR PETS RECORDS? YES / NO

PAYMENT POLICY

ALL FEES ARE DUE AT THE COMPLETION OF EACH VISIT. In cases of extensive medical or surgical procedures where full payment may be difficult at discharge, we accept major credit cards or can establish a payment arrangement if approved in advance of treatment. There will be a service charge for any check returned unpaid.

YOUR PAYMENT METHOD WILL BE: _____ CASH _____ CHECK _____ MASTERCARD
DISCOVER _____ *CARE CREDIT
VISA

* IF YOU ARE NOT FAMILIAR WITH CARE CREDIT, PLEASE ASK US FOR DETAILS

SIGNATURE OF OWNER OR AGENT _____

Please complete questions on next page.

Brief History:

1. Has your pet been examined in the last 12 months and if so, for what reason? _____yes _____no

2. Has your pet ever experienced any allergic reaction to a prescribed medication? _____yes _____no
If so, which one(s)? _____
3. Does your pet have direct contact with other animals? _____yes _____no
If yes, please explain: _____
4. Has your pet ever had difficulty with anesthesia or tranquilizing drugs? _____yes _____no
If yes, please explain: _____
5. Is your pet currently on medication? _____yes _____no
If yes, which meds: _____

Please list any other information that may assist the veterinarian in evaluation of your pet's health condition:

So that we are able to suit your individual needs, which do you feel applies to you:

Check One.

- ___ I feel that my pet is another member of our family.
___ I feel that my pet is just a pet.

Check One.

- ___ I want the best medical care available for my pet; please recommend anything necessary for good health.
___ I want good medical care for my pet, but there is a limit to what I am able to have done.
___ I want you to perform only the services that I request.

Check One.

- ___ I want to learn as much as I can about pet health care - please give me detailed information on what's needed.
___ I would prefer you just summarize what has been done for my pet or what is needed.
___ I want my pet healthy, but don't need to know what has been done.

Check One.

- ___ I prefer to be present when my pet is examined and treated.
___ I would rather not see my pet examined and treated.

Would you like us to keep you informed about procedures to lengthen your pet's life?

- YES NO

Thank you for taking the time to fill out this form in advance. If you have any questions please feel free to contact us at:

Oakwood Hills Animal Hospital
4616 Commerce Valley Road
Eau Claire, WI 5470
715-835-0112