

ST. FRANCIS 24 HOUR ANIMAL HOSPITAL
CLIENT / PATIENT INFORMATION FORM

CLIENT INFORMATION: Name: \_\_\_\_\_

Spouse/Co-owner's name: \_\_\_\_\_

Address: \_\_\_\_\_
STREET CITY, STATE ZIP CODE

Home/Primary #: \_\_\_\_\_ Work #: \_\_\_\_\_

Other #'s: \_\_\_\_\_ Please call this number first: Home / Work / Other

Email address: \_\_\_\_\_ (used only for pet reminders)

If St. Francis is not your PRIMARY Veterinary Hospital, please list who is: \_\_\_\_\_

\*I am eligible for St. Francis' Senior Citizen Discount since I am 60 years of age or older - ( ) YES\*

(1) PET INFORMATION: Name: \_\_\_\_\_

[ ] Dog [ ] Cat [ ] Bird [ ] Rabbit [ ] Ferret [ ] Reptile/Amphibian [ ] Other: \_\_\_\_\_

Breed: \_\_\_\_\_ Color: \_\_\_\_\_

Birth date or Approx. Age: \_\_\_\_\_ [ ] Spayed Female [ ] Female [ ] Neutered Male [ ] Male

Reason for Visit: \_\_\_\_\_

HAS YOUR PET HAD... (Please circle and list date)

- 1. Allergies to any vaccines, medication, food, etc? YES NO \_\_\_\_\_
2. Rabies vaccination within the last 3 years? YES NO DATE LAST GIVEN: \_\_\_\_\_
3. Yearly vaccinations within the last year? YES NO DATE LAST GIVEN: \_\_\_\_\_
4. Medication for a current medical problem? YES NO \_\_\_\_\_
5. A recent physical examination? YES NO \_\_\_\_\_
6. Any previous medical work-up or tests? YES NO \_\_\_\_\_

Please describe your pet's diet (Brand Name/Type/Canned/Dry): \_\_\_\_\_

(2) PET INFORMATION: Name: \_\_\_\_\_

[ ] Dog [ ] Cat [ ] Bird [ ] Rabbit [ ] Ferret [ ] Reptile/Amphibian [ ] Other: \_\_\_\_\_

Breed: \_\_\_\_\_ Color: \_\_\_\_\_

Birth date or Approx. Age: \_\_\_\_\_ [ ] Spayed Female [ ] Female [ ] Neutered Male [ ] Male

Reason for Visit: \_\_\_\_\_

HAS YOUR PET HAD... (Please circle and list date)

- 1. Allergies to any vaccines, medication, food, etc? YES NO \_\_\_\_\_
2. Rabies vaccination within the last 3 years? YES NO DATE LAST GIVEN: \_\_\_\_\_
3. Yearly vaccinations within the last year? YES NO DATE LAST GIVEN: \_\_\_\_\_
4. Medication for a current medical problem? YES NO \_\_\_\_\_
5. A recent physical examination? YES NO \_\_\_\_\_
6. Any previous medical work-up or tests? YES NO \_\_\_\_\_

Please describe your pet's diet (Brand Name/Type/Canned/Dry): \_\_\_\_\_

How did you first hear of our hospital? [ ] Referral; someone we may thank? \_\_\_\_\_

[ ] Yellow Pages [ ] Newspaper Ad [ ] Online [ ] Hospital Sign [ ] Other: \_\_\_\_\_

Receptionist \_\_\_\_\_

Statement of Financial Responsibility:

We will gladly prepare a written estimate if you desire - please ask the receptionist or doctor.

I am aware that I am responsible for all charges for medical services that my pet receives. I understand that I may be asked to leave a deposit for medical services should my pet require a hospital stay. This deposit will be kept at approximately half of estimated charges on a daily basis. In the event of a check returned NSF or stop payment, a \$40.00 fee will be added to my account. I have read and understand St. Francis Animal Hospital's fee policies and my obligation to pay in full at the time medical services are completed.

Signed \_\_\_\_\_ Date \_\_\_\_\_

CLIENT \_\_\_\_\_ PET \_\_\_\_\_