FORM 105-D

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 - [ ]*

**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 [ ] Hospital Sign [ ] DexKnows

[ ] Website [ ] Clark County Fair [ ] Yelp [ ] 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 3/4 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 _____