



Client # _____ For office use only

Thank you for giving us the opportunity to care for your pet. Please help us meet your needs better by taking a moment to complete both sides of this information sheet.

Primary Owner's Name _____

Secondary Owner/Authorized Agent's Name _____

Primary Owner's Mailing Address _____ City _____ State _____ Zip _____

Primary Owner's Home Phone _____ Alternate Phone _____ E-Mail _____

Primary Owner's Employer _____ Phone _____

Name of closest relative not living with you _____

Relative's address _____ Phone _____

For reference purposes we require the following information. For your safety we do not share this information.

Owner's Social Security Number **OR** Driver's License Number _____

How did you hear of our hospital?

_____ Individual or another Doctor who we may thank? _____

_____ Yellow pages

_____ Other _____

Secondary Owner/Authorized Agent Mailing Address _____
(Address) (City) (State) (Zip code)

Secondary Owner/Authorized Agent Home Phone _____ Alternate Phone _____

Secondary Owner/Authorized Agent Employer _____ Phone _____

PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. We will gladly prepare a written estimate for any service upon your request. We accept the following methods of payment: Cash, Check, Master Card, Visa, American Express, Discover and Care Credit. *For your convenience, your credit card number may be kept on file by completing our Auto Pay Form.* This will allow your account balance to be paid or for use in an emergency situation. Please ask any staff member for the Auto Pay Form.

We do not have a 24-hour attendant. There will be periods of time that those animals hospitalized overnight will not be under direct supervision. Please feel free to inquire about our hospitalization policies.

I agree to pay for all professional services and medications rendered in the care of any animal I bring to PRESCOTT ANIMAL HOSPITAL. Furthermore, I understand that in order to prevent the spread of infectious disease and parasites, hospitalized and boarded animals must have documentation of current proof of vaccines and be free of parasites. I authorize Prescott Animal Hospital to provide vaccines and parasite control as needed for my pet.

Owner's Signature _____ Date _____

For office use only: Entered by _____ Date _____
(Initials)

ANIMAL MEDICAL HISTORY
(Please complete for each pet)

Pet Information	Pet #1	Pet #2	Pet #3	Pet #4
Name				
Species				
Breed (please specify if mixed)				
Color				
Date of Birth/Age				
Sex (Male/Female)				
Has your pet been altered? (Y/N)				
Weight				

Vaccinations and Testing	Date of last	Date of last	Date of last	Date of last
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Canine				
Distemper/Parvo				
Kennel Cough/Bordetella				
Rabies				
Other Vaccinations				
Heartworm Test				
Flea and tick preventative				
Dentistry				

Feline				
Distemper/Upper Respiratory				
Leukemia				
FIP				
Rabies				
Other Vaccinations				
FELV/FIV Test				
Flea and tick preventative				
Dentistry				

Previous Veterinarian _____ Phone number _____

Permission is hereby given to have records for the above animals transferred. _____

Additional Information/Comments _____

