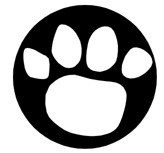
Welcome



Thank you for giving us the opportunity to care for your pet(s). We'll be happy to answer any questions you have about your pet's health. To insure the best care possible, please take the time to fill in this form completely. Thank you!

Owner Information

Owner's Name: ______________________________ Spouse / Significant Other: ______________________________

Address: ____

City: ____ State: __________ Zip: _______________

Primary Phone: ____________________ Secondary Phone: __________________ Other: ___________________

E-Mail Address (only if you approve of e-mail contact): ____

Driver's License Number: _______________________ How Did You Hear of Us? _____________________________

Employer's Name & Address: ____

In Case of **EMERGENCY**, Please Call: _______________________________________ Phone: ___________________

Pet Information

Pet's Name: ____ Species: ☐ Dog ☐ Cat ☐ Other: _______________

Breed: ____________________ Color: ___________________ Sex: ☐ Male ☐ Neutered ☐ Female ☐ Spayed

Date of Birth: _______________ Previous Vet Care Given By: ____

Your Pet's Diet: Brand of Food: ___________________ Amount Fed: _____ Cups _____ x per Day Weight: ______

Vaccination History (Date & Type): ____

Current Medications: ____

Reason for Today's Visit: ____

Please check any symptoms or problems that you have noticed about your pet:

- ☐ Bad Breath
- ☐ Behavior Problems
- ☐ Bleeding Gums
- ☐ Breathing Problems
- ☐ Coughing
- ☐ Diarrhea
- ☐ Eye Bulging / Bloodshot
- ☐ Gagging
- ☐ Lack of Appetite
- ☐ Limping
- ☐ Loss of Balance
- ☐ Scooting
- ☐ Scratching
- ☐ Seems Depressed
- ☐ Shaking Head
- ☐ Sneezing
- ☐ Thirst and/or Urination Increased
- ☐ Vomiting
- ☐ Weakness
- ☐ Weight Problem
- ☐ Other: ____

Authorization

I authorize any doctor employed by Chestnut Mountain Animal Hospital to treat my pet as agreed upon. I understand that situations may arise during anesthesia, hospitalization, or boarding that may require immediate surgical or medical attention. I request that an attempt be made to contact me should the need arise, but I authorize the attending physician to proceed for the most successful outcome. I assume responsibility for all charges incurred in the care of my pet(s). I understand that these charges must be paid at the time of release and that a deposit may be required for surgical treatments. A $30.00 returned check fee will apply to all checks returned. Outstanding balances will accrue 1.5% interest per month. Billing fees may apply.

Owner's Signature: Today's Date:

____

Payment in full is required at the time of pick up. American Express not accepted. Payment plans not available. Estimates available upon request. All prices are subject to change without notice. Thank you for your understanding and cooperation. We appreciate your trust.

Chestnut Mountain Animal Hospital does not accept personal checks.
Payment options include cash, debit, Visa, MasterCard, & Discover.

______________________________ __________
Client Signature Date

Thank you for your understanding.