

Client Information Sheet: Hidden Oaks Animal Hospital – CANINE

Last name: _____ First Name: _____ Title: _____

Street Address: _____ Zip: _____ City: _____
State: _____

County: _____ Cell: _____ Home: _____ Work: _____
Fax: _____

Email: _____ If paying by check: SSN: ____ - ____ - ____ DL: _____

Your Employer: _____ Spouse: _____ Spouse Employer: _____ Spouse cell: _____

How would you prefer we address any written correspondence to you? (Mr/Mrs John Smith, Mary Smith, Ms. Mary Smith, or John Smith and Mary Jones)

How did you find out about us? [Friend]: _____ [Sign]: _____ [Phone Book]: _____ [Website]: _____ [Meet and Greet Tour]: _____ [Other]: _____

Pet #1:

Name: _____ Breed: _____ Color: _____ Age: _____
Birth date: _____

Please Circle Sex: Female/Male/Spayed female/Neutered male. Weight in lbs.: _____

Microchip #: _____ **Known Allergies:** _____

Last vaccines: Rabies ____/____/____, DA2PP: ____/____/____, BORDETELLA: ____/____/____,

CIV: ____/____/____, LEPTO: ____/____/____, Heartworm test: ____/____/____,
Fecal: ____/____/____

Please advise us if your pet has any previous illnesses, allergies, special diets or is on any medications.

Pet #2:

Name: _____ Breed: _____ Color: _____ Age: _____
Birth date: _____

Please Circle Sex: Female/Male/Spayed female/Neutered male. Weight in lbs.: _____

Microchip #: _____ **Known Allergies:** _____

Last vaccines: Rabies ____/____/____, DA2PP: ____/____/____, BORDETELLA: ____/____/____,

CIV: ____/____/____, LEPTO: ____/____/____, Heartworm test: ____/____/____,
Fecal: ____/____/____

Please advise us if your pet has any previous illnesses, allergies, special diets or is on any medications.

All fees are due in full at the time service is rendered. Please feel free to ask for a written treatment plan and expected fees BEFORE any procedures are done. Our doctors will be happy to explain the plan and costs if you have any questions or concerns. A Cat's Hospital at Hidden Oaks/ Hidden Oaks Animal Hospital and the doctors will not be responsible for items lost or damaged while boarding or hospitalized. By signing below, you are certifying that you are over 18 years of age and are the owner or have been authorized by the owner to act as their agent, and have read, understand and agree to the above.

Signature: _____ Date: _____