

CLIENT INFORMATION

NAME _____ DATE _____
HOME ADDRESS _____ HOME PHONE _____
CITY _____ STATE _____ ZIP _____ CELL PHONE _____
DRIVER'S LICENSE NO. (Optional) _____ EXP. DATE _____
EMPLOYER _____ OCCUPATION _____
BUSINESS ADDRESS _____ BUSINESS PHONE _____
SPOUSE OR CO-OWNER _____ EMPLOYER _____
OCCUPATION _____ SPOUSE/CO-OWNER'S WORK PHONE _____
IF NECESSARY, MAY WE CALL YOU AT WORK? _____ SPOUSE CELL PHONE _____
ARE THERE CHILDREN IN THE HOUSE? _____ NO _____ YES HOW MANY? _____ AGES? _____
IS THIS YOUR FIRST VISIT TO THIS HOSPITAL? _____ IF CHANGING PET CARE FACILITIES, WHAT IS THE
REASON FOR YOUR CHANGE? _____
HOW DID YOU LEARN OF THIS PRACTICE? _____ YELLOW PAGES _____ HOSPITAL SIGN _____ WEBSITE
_____ PERSONAL RECOMMENDATION - WHO MAY WE THANK? _____
PLEASE SHARE YOUR E-MAIL ADDRESS: _____

BY SHARING YOUR EMAIL YOU CAN RECEIVE REMINDERS, REFILL PRESCRIPTIONS, REQUEST APPOINTMENTS, CHECK VACCINATION DUE DATES, ETC. FOR YOUR PET(S)

I AUTHORIZE MY PET'S MEDICAL RECORDS TO BE RELEASED TO ANY VETERINARY RELATED BUSINESS: YES ☐ NO ☐

PATIENT INFORMATION

PET'S NAME _____ BREED _____ COLOR _____
AGE _____ DATE OF BIRTH _____ SEX _____ SPAYED/NEUTERED? YES / NO
WHERE DID YOU ACQUIRE PET? (ie. BREEDER, SHELTER, PET SHOP, OTHER) _____
DATE OF PET'S LAST VACCINATIONS _____
NAME OF HOSPITAL/CLINIC WHERE GIVEN: _____ PHONE _____
DO WE HAVE YOUR PERMISSION TO CONTACT YOUR PREVIOUS VETERINARIAN FOR YOUR PETS RECORDS? YES / NO
DO WE HAVE YOUR PERMISSION TO ADD YOUR NEW PET'S PICTURE TO OUR WEBSITE? YES / NO

PAYMENT POLICY

ALL FEES ARE DUE AT THE COMPLETION OF EACH VISIT. In cases of extensive medical or surgical procedures where full payment may be difficult at discharge, we accept major credit cards and Care Credit. There will be a service charge for any check returned unpaid.

YOUR PAYMENT METHOD WILL BE: _____ CASH _____ CHECK _____ MASTERCARD
DISCOVER _____ *CARE CREDIT
VISA

* IF YOU ARE NOT FAMILIAR WITH CARE CREDIT, PLEASE ASK US FOR DETAILS

SIGNATURE OF OWNER OR AGENT _____

Brief History:

1. Has your pet been examined in the last 12 months and if so, for what reason? _____yes _____no

2. Has your pet ever experienced any allergic reaction to a prescribed medication? _____yes _____no
If so, which one(s)? _____
3. Does your pet have direct contact with other animals? _____yes _____no
If yes, please explain: _____
4. Has your pet ever had difficulty with anesthesia or tranquilizing drugs? _____yes _____no
If yes, please explain: _____
5. Is your pet currently on medication? _____yes _____no
If yes, which meds: _____

Please list any other information that may assist the veterinarian in evaluation of your pet's health condition:

So that we are able to suit your individual needs, which do you feel applies to you:

Check One.

- ___ I feel that my pet is another member of our family.
___ I feel that my pet is just a pet.

Check One.

- ___ I want the best medical care available for my pet; please recommend anything necessary for good health.
___ I want good medical care for my pet, but there is a limit to what I am able to have done.
___ I want you to perform only the services that I request.

Check One.

- ___ I want to learn as much as I can about pet health care - please give me detailed information on what's needed.
___ I would prefer you just summarize what has been done for my pet or what is needed.
___ I want my pet healthy, but don't need to know what has been done.

Check One.

- ___ I prefer to be present when my pet is examined and treated.
___ I would rather not see my pet examined and treated.

IF YOU ARE INTERESTED IN A TOUR OF OUR HOSPITAL, PLEASE ASK ONE OF OUR STAFF MEMBERS

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