

Welcome to Chickasaw Trail Animal Hospital

Thank you for giving us the opportunity to care for your pet. So that we may become better acquainted please complete the following:

Dr. Mr. Mrs. Ms. Miss

Last Name _____ First Name _____

Address: _____

Apt. or Bldg. # _____ City _____ State _____ Zip _____

Home Phone _____ Cell/Pager # _____ E-Mail _____

Place of Employment _____ Work Phone _____

Please indicate which telephone number you would prefer we call, should we need to reach you during business hours. Home Work Cell

Spouse's Name _____ Cell # _____

Spouse's Place of Employment _____ Work Phone _____

How did you learn of our hospital? (check all that apply)

- Bell South/AT&T Yellow Pages (yellow book) DexYellow Pages Internet/Web-site Facebook
 Humane Society Hospital Sign Location/Neighborhood Other _____
 Personal Recommendation-whom may we thank? _____

If your pet has records at another veterinary hospital, may we request a transfer of these records?

Yes No If yes, please give us the name of the hospital: _____

Address _____ City _____ State _____ Zip _____

Do you have any children at home? If so, please tell us their names and ages:

Child's Name _____ Age _____

Child's Name _____ Age _____

TO PREVENT THE SPREAD OF INFECTIOUS DISEASES AND PARASITES, HOSPITALIZED AND BOARDED PETS MUST BE CURRENT ON ALL VACCINES.

PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. WE WILL GLADLY PREPARE A WRITTEN TREATMENT PLAN UPON REQUEST.

PLEASE CIRCLE METHOD OF PAYMENT: CASH CHECK VISA/MC DISCOVER DEBIT CARECREDIT

I AUTHORIZE THE DOCTORS ON STAFF AT CHICKASAW TRAIL ANIMAL HOSPITAL TO EXAMINE, TREAT, PRESCRIBE FOR, OR OPERATE UPON MY PET AND I UNDERSTAND THAT ALL REASONABLE PRECAUTIONS WILL BE TAKEN AGAINST INJURY, ESCAPE, OR DEATH. I UNDERSTAND IF THIS ACCOUNT IS ASSIGNED TO A COLLECTION AGENCY AN ADDITIONAL FEE OF 40% OF THE AMOUNT OWED WILL BE ADDED. BALANCES OVER 30 DAYS WILL ACCRUE FINANCE CHARGE AT 1.5% MONTHLY.

OWNER'S SIGNATURE _____ DATE _____

OTHER SIGNATURE _____ RELATION _____

PLEASE COMPLETE PET HISTORY ON BACK

FOR OFFICE USE:

Date: _____

Client #: _____

Receptionist: _____

I/A: _____

PET INFORMATION (please fill in the following for each pet)

	PET 1	PET 2	PET 3
NAME			
MICROCHIP NUMBER			
SPECIES Cat, Dog, Other			
BREED			
COLOR/MARKINGS			
DATE OF BIRTH			
SEX			
SPAYED/NEUTERED			
LENGTH OF TIME OWNED			
HOURS SPENT OUTSIDE EACH DAY			
DIET (kind of food)			
DATES OF VACCINATIONS/TESTS			
DHLP (Distemper) (Dog)			
PARVOVIRUS (Dog)			
CORONA (Dog)			
BORDETELLA (Both)			
RABIES (Both)			
FVRCP (Cat)			
LEUKEMIA (Cat)			
LEUKEMIA TEST (Cat)			
FIV TEST (Cat)			
FECAL TEST (Worms)			
HEARTWORM TEST			
ON HEARTWORM PREVENTIVE?			
DENTISTRY			
PRIOR ILLNESS OR SURGERY			
WOULD YOU LIKE INFORMATION ON PET INSURANCE?			
WOULD YOU LIKE INFORMATION ON MICROCHIPPING YOUR PET?			

Is there any special health care or behavior question we can help you with today? _____

Our records are computerized. Please help us keep them up to date by letting us know when you make any changes.

Thank you for your help in completing our records. We look forward to a lifetime of taking care of your pets.