

ACCOUNT NO. \_\_\_\_\_

Thank you for giving Grassmere Animal Hospital the opportunity to care for your pet! So that we may become better acquainted and serve you better, please complete the following:

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Are you the owner of the pet(s) with you today? YES NO If not, who is the owner: \_\_\_\_\_

YOUR NAME: Mr. Mrs. Dr. Ms. \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

MAILING ADDRESS (if different): \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

PLACE OF EMPLOYMENT: \_\_\_\_\_ POSITION: \_\_\_\_\_

SPOUSE NAME: Mr. Mrs. Dr. Ms. \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

SPOUSE'S EMPLOYMENT: \_\_\_\_\_ POSITION: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

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Who else may we contact Name: \_\_\_\_\_ PHONE: \_\_\_\_\_  
in case of emergency?  
close friend or relative) Address: \_\_\_\_\_

How did you become aware of our hospital? (Please circle)  
YELLOW PAGES CLINIC SIGN WEB SITE PERSONAL RECOMMENDATION OTHER \_\_\_\_\_

If personal recommendation, whom may we thank? \_\_\_\_\_

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There may be occasions that someone other than yourself will bring your current or future pets to this hospital for services. In order to protect your financial records here, **please list the people you authorize to bring your pets, or to add a new pet to your account here. You will consequently assume financial responsibility for these charges.**

Please note – anyone not listed will be unable to present your pet for services or add fees to your account.

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

Please notify us immediately if you need to add or delete an authorized user.

## PET INFORMATION

PLEASE FILL OUT FOR EACH PET WITH YOU TODAY

	PET #1	PET #2	PET #3
YOUR PET'S NAME			
SEX	Male Female	Male Female	Male Female
NEUTERED OR SPAYED	Yes No	Yes No	Yes No
BIRTHDATE OR ESTIMATED AGE			
SPECIES (Dog, cat, other)			
BREED			
COLOR			
MICROCHIPPED	Yes No	Yes No	Yes No
CURRENT MEDICATIONS			
DRUG OR VACCINE ALLERGIES			
PRIOR ILLNESS OR SURGERY			

## PAYMENT POLICY

All fees are due and payable upon release of the patient. Please indicate your choice of payment:

CASH CHECK VISA MASTER CARD DISCOVER CARD

A deposit will be required for any pet left at the hospital for medical treatment or for boarding.

\_\_\_\_\_

Client signature

\_\_\_\_/\_\_\_\_/\_\_\_\_

Date of birth

\_\_\_\_/\_\_\_\_/\_\_\_\_

Today's date

For office use only:

Ver: \_\_\_\_\_ w/: \_\_\_\_\_ Cl/En: \_\_\_\_\_ NCL: \_\_\_\_\_ BSMNT: \_\_\_\_\_