

Long Animal Hospital - New Client Information

We appreciate the opportunity to care for your pet(s). To better serve you, please complete this form.

Please Print

Date _____

Owner's Name _____

Spouse/Other _____

Address _____ City _____ State _____ Zip Code _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Email Address _____

What time is best to call about your pet? ___AM___PM And at what number _____?

In case of emergency, call _____ at phone number _____

Would you like to receive text message updates about your pet(s)? ___Yes ___ No Best # _____

How did you become aware of our clinic? ___ Referral ___ Hospital Sign ___ Internet ___ Other, please specify _____

Pet Information

Pet's Name _____ Species _____ Breed _____

Color _____ Date of Birth _____ Sex ___ Male or Female ___ Spayed/Neutered _____

Pet's Name _____ Species _____ Breed _____

Color _____ Date of Birth _____ Sex ___ Male or Female ___ Spayed/Neutered _____

Name of previous / current Veterinarian _____

Is your pet currently receiving any medication? ___ Yes ___ No What? _____

Does your pet have any known drug allergies? ___ Yes ___ No What? _____

ALL FEES ARE DUE AND PAYABLE UPON COMPLETION OF SERVICES

Method of payment ___ Cash ___ Check ___ Credit Card ___ Debit Card ___ Care Credit

I understand that every effort will be made to achieve a successful outcome and to provide for all safety in the hospital care and handling. In the event of an emergency, all necessary medical services will be provided to maintain the health of the patient unless otherwise stated by owner. I hereby authorize this hospital to receive, prescribe for, and treat the pet(s) listed above. Furthermore, I agree to pay all fees for all services rendered at the time the pet is discharged from the hospital. I understand that veterinary service is provided during night time hours as necessary in the judgment of the veterinarian in charge.

Signature _____ Date _____

Hospital Employee _____ Date _____