PATIENT/CLIENT INFORMATION

Welcome to Peninsula Animal Hospital and Orthopedics. Please help us meet your needs by taking a moment to complete this form.

Owner's Last Name: _____ First Name: _____

Home Number: _____ Cell: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Occupation: _____ Employer: _____

Work Number: _____ Can we contact you at work? _____

Spouse/other: _____ Spouse/other cell: _____

Work Number: _____ Referral by: _____

Do you want our records faxed to anyone, if yes, whom? _____

Driver's Lic. #_____ State_____ Exp. _____ SS #_____

****

****

Please provide an estimate for any *in hospital* service(s) that may cost $_____ or more

How did you hear about our practice?

____ Verizon Yellow Page Ad?

_____ Local Book Ad?

_____ Word of Mouth/Neighbor/Friend/Colleague? If so, who? _____
_____ Online Search for Veterinarian?

_____ Referral from regular veterinarian? If so, what is their name so that we may thank him or her? _____

_____ Other method of finding us? _____

How would you prefer to be contacted by our office? (FILL OUT ***ALL*** THEN CHECK ***ONE*** PLEASE)

___ Email (_____)

___ Telephone (Best contact number: _____)

___ Text Message (Cell phone number: _____)

___ Mail

Photo Release Form

I grant to Peninsula Animal Hospital & Orthopedics, its representatives and employees the right to take photographs of me and/or my pet, and to copyright, use and publish the same in print and/or electronically.

I agree that Peninsula Animal Hospital & Orthopedics may use such photographs of me and/or my pet with or without my name and for any lawful purpose, including, for example, such purposes as publicity, illustration, advertising, and Web content.

❍ The above may take photos of me and/or my pet

❍ The above may **NOT** take photos of me and/or my pet

Signature: _____

Printed name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Date: _____

PLEASE LIST INDIVIDUAL PET INFORMATION:

	PET #1	PET #2	PET #3
Name of Pet			
Cat or Dog or Other?			
Breed			
Description/Color			
Age/Date of Birth			
Sex & is it Spayed/Neuter?	F FS M MN	F FS M MN	F FS M MN
Previous Hospital/Vet			
Microchip #			
Vaccination			
DA2PP (distemper)			
Bordetella			
Rabies			
FVRCP (Cats)			
Any Other Vaccines?			

If dates for vaccines unknown, may we contact the regular veterinarian for information? YES/NO

Please tell us more about your pets:

	PET #1	PET #2	PET #3
What medications is your pet currently taking? Please include the last time the pet received the medication.			
What food does your pet eat? How many times a day?			
Is he/she allowed to eat 'people' food?			

Please tell us ANY other concerns you have with your pet.			
	PET #1	PET #2	PET #3
Does your pet have any allergies or reactions to foods?			
Does your pet have any allergies or reactions to any medications?			
Has your pet ever had any reactions to vaccinations?			
Has your pet ever been sick or hospitalized before? If yes, please explain.			

New Concerns about my Pet Include:

_____

_____

_____

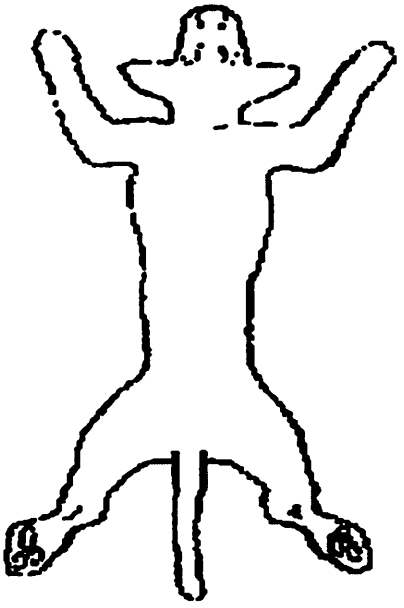
_____

_____

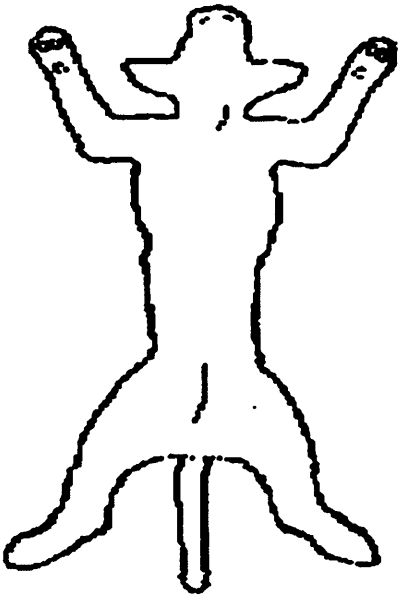
Are there any new lumps/growths (less than 6 months old)? _____

Please X any lumps/growths or broken bones on the chart below:

Left TOPSIDE Right



Right UNDERSIDE Left



Please read, sign and date this page so that we may treat your pet.
Thank you.

****

We require current rabies vaccination for our safety. To prevent the spread of infectious diseases, we recommend but do not require animals be current on vaccines. We assume no liability for pets or humans contracting infectious diseases or parasites. Pets with fleas will be treated with a topical or oral flea product on admission; the price will be included on the invoice.

I AUTHORIZE ADMINISTRATION OF RABIES VACCINES AND PARASITE CONTROL AS NEEDED FOR MY PET(S).

A DEPOSIT OF 50% OF THE ESTIMATED HOSPITAL STAY MAY BE REQUIRED FOR PETS BEING ADMITTED.

We accept cash, checks drawn from a local bank*, credit cards; VISA, MasterCard, Discover and CareCredit.

We charge a $30.00 fee for returned checks along with a 3% interest fee and a monthly fee of $5.00 on any balances not paid.

*****AT YOUR REQUEST WE WILL GLADLY DISCUSS COST OF SERVICES AND/OR PREPARE A WRITTEN ESTIMATE FOR RECOMMENDED PROCEDURES/SERVICES. *****

PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.

****

I, the undersign, have read, understand and agree to the information stated in this form:

SIGNATURE _____ **DATE** _____