NEW PATIENT INFORMATION SHEET

Owner's Last Name:_____ First Name:_____

Street Address: (No PO Box)_____

City, State, Zip: _____

Home Phone Number:_____ Cell Phone Number: _____

Employer: _____ Work Phone Number:_____

Spouse's or Significant Other's Name: _____Phone number_____

Which phone number do you prefer us to use? Home Cell Work Spouse/Sig. other's phone

Email Address (for reminders and other important news): _____

How did you hear of us? (friend, driving by, etc.) _____

If one of our clients referred you, whom can we thank? _____

Pet's Name: _____

Species (Circle One): Dog Cat Bird Rabbit Ferret Other

Sex: Female Female Spayed Male Male Neutered

Breed:_____ Color:_____

Date of Birth:_____

Any known allergies?_____

Any significant chronic problems?_____

Is your pet on any chronic medications? _____

Date of last Rabies vaccination_____ One-year or three-year vaccine? _____

Reason for your visit today?_____

Please list names of any and all individuals allowed to make medical and financial decisions on your behalf: (must be over 18 years of age to accompany patient for visit without owner present)

1._____ 2._____ 3._____

I give permission to the West Hempstead Animal Hospital Doctors and Staff to examine, diagnose and treat my pet.

I understand that I am fully responsible financially for the care of my pet, and that in cases of non-payment, interest and collection fees will apply.

Authorized Signature_____ Date _____

** We accept cash, Mastercard, Visa, Discover, American Express and Care Credit. We do not accept checks **