CLIENT / PET INFORMATION FORM

Date: _____

OWNER'S NAME: _____
Last Name First Name M.I. Spouse / Other First Name

ADDRESS:_____
Number Street City State Zip

PHONE: (_____)_____(_____)_____(_____)_____
Home Work Cell

PHONE: (_____)_____(_____)_____(_____)_____
Spouse / Other Work Spouse / _Other Cell Other

E-MAIL: _____

VERIFICATION BY PHOTO IDENTIFICATION IS REQUIRED

Pet Information	Pet # 1	Pet # 2	Pet # 3	Pet # 4
Name				
Species (Canine / Feline)				
Breed				
Date of Birth				
Color				
Sex	(circle) Male Female Altered	(circle) Male Female Altered	(circle) Male Female Altered	(circle) Male Female Altered

Vaccine History

Feline/K9 Rabies				
K9 Distemper/Parvo Or Feline Distemper				
Bordatella				
Feline FIP				
Feline FeLV				
Feline FIV				

Please sign the following authorization for treatment

I hereby authorize the staff of Young's Animal Hospital to render treatment which is deemed necessary to my pet(s) health while in custody of the hospital. I understand that in the event of any unusual or emergency circumstances, the staff will make every attempt to contact me or my designated representative before, if time permits, proceeding with treatment. I understand that I will be financially responsible for all emergency procedures including the estimate of charges provided to me in person or over the telephone. I understand that professional fees are to be paid at the time services are rendered and a deposit is required on all pets admitted to the hospital.

_____ _____
Signature of Owner, Agent, Good Samaritan (circle one) Signature of Spouse

Please circle your method of payment: CASH CHECK VISA MASTERCARD DISCOVER CARE CREDIT