APPALACHIAN ANIMAL HOSPITAL
CLIENT/PATIENT INFORMATION

Thank you for giving us the opportunity to care for your pet(s). So that we may become better acquainted, please complete the following:

Name____
Address____
City______________State______Zip___________________________________
Phone___________________Work Phone______________________________
Place of Employment____
Driver's License #____

Spouse's Name____
Phone_______________ Work Phone___________________________________
Place of Employment____
Driver's License #____

* ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED*

WE DO NOT BILL

Please indicate choice of payment.
Cash Check Visa/Mastercard/Discover

How did you become aware of our clinic?
Drove by Yellow Pages Previous Client
*Personal Recommendation(Whom may we thank?)
Name:____

Please list any person(s) authorized to bring your/their pets in under your account:
1.____
2.____
3.____

There will be a charge of $30.00 or 5%, whichever is greater, on all returned checks. If this account is referred to outside collections I will be responsible for collection fees, and/or legal or attorney fees.
I will be responsible for payment of all charges incurred on behalf of my animal(s).

Signature____Date___________

Revised:____,20__/_____,20__/_____,20___

PATIENT INFORMATION

	PET #1	PET #2	PET #3
NAME			
SPECIES			
BREED			
DATE OF BIRTH			
COLOR			
SEX; SPAYED OR NEUTERED?			
VACCINATED WITHIN LAST YEAR?			
HEARTWORM TEST/PREVENTION?			
HAS CAT BEEN TESTED FOR FELV/FIV?			

Our pet(s) is: Member of our family Child's pet Backyard pet

Any previous serious illnesses or surgeries?____________________________

____

Any allergies to vaccinations or medications?____________________________

____

Is your pet on any special diets or medications?__________________________

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