



**All Pets Hospital, Ltd.**  
 200 Read Street  
 Lockport, IL 60441  
 (815) 838-0505

Client Information

Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Driver's license # (required if writing a check): \_\_\_\_\_

County: Will Cook DuPage Grundy Other: \_\_\_\_\_

Pet Information

| Pet's Name | Dog | Cat | Breed | Color | Date of Birth / Age | Sex | Spayed/ Neutered |
|------------|-----|-----|-------|-------|---------------------|-----|------------------|
|            |     |     |       |       |                     |     |                  |
|            |     |     |       |       |                     |     |                  |
|            |     |     |       |       |                     |     |                  |

Other Information

Referred / Recommended by: \_\_\_\_\_ Previous veterinarian / hospital: \_\_\_\_\_

Is your pet microchipped? Y N Number: \_\_\_\_\_ Usual diet: \_\_\_\_\_

Does your pet have allergies (i.e. food, fleas, drugs, etc)? Y N List: \_\_\_\_\_

Please list any major diseases, illness, or injury your pet has had: \_\_\_\_\_

Currently on medication? Y N List: \_\_\_\_\_

How did you acquire your pet? \_\_\_\_\_ How long have you had your pet? \_\_\_\_\_

**FEES ARE TO BE PAID AT TIME SERVICES ARE RENDERED**

I certify that I am the owner / responsible party of the animal(s) listed above. I am at least 18 years of age and I assume total financial responsibility for the costs of services rendered by All Pets Hospital.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ APH Initial: \_\_\_\_\_