Welcome to

Orchard Grove Animal Hospital

Today's Date: _____

Client Information

First Name: _____Spouse's Name_____ Last Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____-_____ Cell: ( ) _____-_____ Work: ( ) _____-_____

E-mail Address: _____

Best number to reach you? ☐Home ☐Cell ☐Work

Patient Information

Name: _____ Canine ☐ Feline ☐ Breed: _____

Sex: Male ☐ Female ☐ Color: _____

Birthday (approx.):_____/_____/_____ Age: _____ Spayed ☐ Neutered ☐

Authorization to Release Previous Veterinary Records

I certify that I am the owner or authorized agent of the pet(s) listed above, and hereby request and authorize the release of medical information for my pet(s) to Orchard Grove Animal Hospital.

Previous Veterinary Hospital's Name: _____

May we call for previous medical records? Yes ☐ No ☐

Owner's Signature_____ Date___/____/____

Authorization of Treatment

I hereby authorize Orchard Grove Animal Hospital to examine, prescribe for, and treat the above described pet. I assume responsibility for all charges incurred in the care of the animal. ***I also understand that payment is due at the time of service.*** Orchard Grove Animal Hospital will gladly prepare a written estimate for any procedure upon request.

Owner's Signature: _____ Date: _____/_____/____