



Cypress Falls Animal Hospital
9405 Huffmeister Rd Suite 170
Houston, TX 77095
(281) 858-7700 Fax: (281) 401-9676
www.cypressfallsah.com

Client #: _____

BETTY HALBROOK, DVM HEATHER THOMAS, DVM BEKKI WATTS, DVM

Client Information:

OWNER'S NAME (1): _____

SPOUSE/PARTNER/CO-OWNER (2): _____

ADDRESS: Street _____ Apt _____

City _____ St _____ Zip _____

PHONE: HOME: _____ FAX: _____

CELL (1): _____ CELL (2): _____

WORK (1): _____ WORK (2): _____

IN CASE OF EMERGENCY (OTHER THAN SELF): Name: _____ Phone: _____

Email is our primary form of communication for sending vaccine reminders, upcoming promotions and discounts, vendor coupons, etc. Please provide your preferred email address so that we may provide these important services

EMAIL: _____

EMPLOYER (1): _____ EMPLOYER (2): _____

DRIVER'S LICENSE (1): # _____ ST _____ DOB _____

(2): # _____ ST _____ DOB _____

HOW DID YOU LEARN OF OUR CLINIC? (PLEASE CIRCLE ONE)

Client, Employee or Clinic/Hospital Referral (Whom may we thank?) _____

Internet Source _____ ☐ Location/Drive-By ☐ Shelter/Rescue ☐

Neighborhood Newsletter ☐ Other _____

WHAT QUALITIES DO YOU SEEK IN A VETERINARIAN? _____

We accept the following forms of payment:

MasterCard, Visa, Discover, American Express, Debit Card, Care Credit and Cash *No Checks Please*

I hereby authorize the veterinarian to examine, prescribe for, and treat each of my pets on record. I assume financial responsibility for all charges incurred in the care of each pet. I understand that payment is required at the time services are rendered and that a deposit may be required for hospitalization, surgery or other treatments. I also understand that I may request an estimate for such services.

Owner / Agent Signature: _____ **Date:** _____