Berwick Animal Clinic, Ltd.
3272 Refugee Road • Columbus, Ohio 43232
Phone: 614-236-8549 • Fax: 614-347-9052 • www.berwickanimalclinic.com

PATIENT / CLIENT INFORMATION

Thank you for giving us the opportunity to care for your pet. Please help us better meet your needs by taking a few moments to fill out this information sheet.

Owner's Name: _____ Spouse/Other: _____

Owner's Social Security Number: _____ Spouse/Other SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone #: _____ Cell Phone #: _____

Home Phone #: _____ Work Phone #: _____

Email Address: _____

Email addresses will be used by Berwick Animal Clinic ONLY. We will not solicit it. You will be able to receive reminders for your pet's needs as well as appointments scheduled. Please ask us if you have any questions about our email policy.

We will gladly prepare a written estimate if you so desire. Please ask a technician or Doctor. Professional fees are due at time services are rendered.

How did you hear of our hospital? We place a $25 credit on current client's account if they refer someone to us. Has one of our clients referred you? If so, please let us know.

( ) Individual, someone we may thank? _____
( ) Internet, what website? _____
( ) Yellow Pages?
( ) Hospital sign, noticed building driving by?
( ) Other, please state, _____

To help prevent the spread of infectious diseases, ALL hospitalized and boarded animals MUST be current on all vaccinations. **Due to state law and insurance requirements, ALL DOGS & CATS MUST BE CURRENT ON RABIES VACCINATION.** Vaccinations can be updated at the time of your appointment if not current.

TO ALL CLIENTS: FEDERAL LAW PROHIBITS THE DISPENSING OF CERTAIN MEDICATIONS WITHOUT EXAMINATION OR PRESCRIPTION. YOUR UNDERSTANDING IS APPRECIATED.

I understand every effort will be made to achieve a successful outcome and to provide for all possible safety in hospital care and handling. I hereby authorize this hospital to receive, prescribe for, treat or perform surgery upon the pet(s) I present. Furthermore, I agree to pay fees for services rendered at time the pet is discharged from the hospital or the service is otherwise terminated. I understand that service fee of $25.00 will be assessed for each non-sufficient funds check and/or certified letter that must be sent. I understand that veterinary service is provided during nighttime hours as necessary in the judgement of the veterinarian in charge. Continous presence of qualified personnel may not be provided.

Signature: _____ Date: _____

PLEASE ENTER PET INFORMATION ON BACK

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PATIENT / CLIENT INFORMATION

Pet's Name: ______________________ Species: ☐ Cat ☐ Dog

Age: __________ Color: ____________________ Breed: ____________________

Sex: ☐ Male ☐ Female Spay/Neuter: ☐ Yes ☐ No

Pet's Name: ______________________ Species: ☐ Cat ☐ Dog

Age: __________ Color: ____________________ Breed: ____________________

Sex: ☐ Male ☐ Female Spay/Neuter: ☐ Yes ☐ No

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Pet's Name: ______________________ Species: ☐ Cat ☐ Dog

Age: __________ Color: ____________________ Breed: ____________________

Sex: ☐ Male ☐ Female Spay/Neuter: ☐ Yes ☐ No