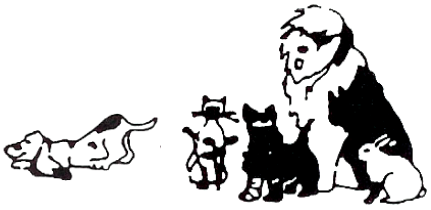
Animal Hospital of Warwick, P.C.



Patient/Client Information

Thank you for giving us the opportunity to care for your pet. Please help us meet your needs better by taking a moment to complete **BOTH** sides of this information sheet.

Owner's Name_____ Spouse/Other_____

Do any children live with this pet? (Please list first names and ages)

_____

Owner's Address:

Street: _____ City_____ State_____ ZIP_____

Email Address: _____

Home #_____ Cell # (Owner) _____ Cell # (Spouse/Other) _____

May we contact you at work? ☐ Yes ☐ No Work #_____Ext_____

Employer's Name/Address _____

Spouse/Other's Employer's Name/Address_____

At what time _____and at what phone # _____is it best to call about your pet?
(If you prefer to be contacted by email, please write "email" in the space above).

In case of EMERGENCY, please call _____ at phone #_____

How did you first hear of our hospital? ☐Hospital Sign ☐Internet (Google, other)

☐An individual we may thank: _____

☐Other:_____

We will gladly prepare an estimate for you upon request.
PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.
We accept Cash, Check, Visa, MasterCard, American Express, Discover and Debit Cards.
We require a DRIVER'S LICENSE NUMBER on file.

Driver's License:
State: _____ Number: _____

This information will be kept strictly confidential.

Consent to Treatment and Financial Responsibility

I hereby authorize Animal Hospital of Warwick, PC to examine, prescribe for, and treat my pet(s). I further authorize the Animal Hospital of Warwick, PC to provide vaccines and parasite control as needed for my pet(s) to comply with all applicable laws and to prevent the spread of infectious diseases and parasites. I understand that Animal Hospital of Warwick, PC cannot guarantee success of any treatment provided for my pet(s), and that I am responsible for payment of all charges incurred regardless of the results, at the time services/treatments are rendered.

Owner's Signature_____Date_____

(Form Continues on Back)

Animal Identification and Medical Information

Name of Client_____ Please complete **ALL** information for each NEW pet.

	Pet #1	Pet #2	Pet #3
Pet's Name			
Species (i.e. Dog, Cat, Rabbit, etc.)			
Breed			
Description / Color			
Date of Birth			
Sex F/M			
Spayed/neutered			
Length of Time Owned			
How/where did you acquire your pet?			
Microchip #			
Hours spent outside daily			
Heartworm / Internal Parasite Prevention Product Used			
Is this product used continuously, all year?			
Flea / Tick Prevention Product Used			
Is this product used continuously all year?			
Current Medications			
Diet			
Prior Illness/Injury			
Prior Surgery/Dentistry			

Do you have any prior vaccine history with you? Yes No
(If so, please give records to the receptionist to make a copy for your pet's record, or email records to office@animalhospitalofwarwick.com.)

If not, may we call your pet's previous veterinarian and request a copy of records to be made part of your pet's permanent record here? Yes No

Previous Veterinarian: _____

Address: _____ Phone #_____

Additional Comments:

_____