



SPRING CREEK
Confidential Client/Pet Information

Owner:

Last Name _____ First Name _____ M _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Cell phone ____/____/____ Work ____/____/____ Home ____/____/____

Email address _____

Employer _____ Occupation _____

Drivers License # _____ State _____

Co-Owner: Last Name _____ First Name _____

Cell phone ____/____/____

Approve use of pictures of your pet(s) for our Social Media? YES or NO

How did you learn of our hospital? Google ____ Yelp ____ Facebook ____ Sign ____ Referral ____ Other ____

If referred, by whom (so we can thank them) _____



Pet Health History

Pet #1

Name of pet _____ Dog Cat Other _____

Breed _____ Color _____ Birthday ____/____/____

Male Neutered Female Spayed

Pet #2

Name of pet _____ Dog Cat Other _____

Breed _____ Color _____ Birthday ____/____/____

Male Neutered Female Spayed

To help protect against check & credit card fraud, we may require two forms of I.D. on all transactions.

Authorization

I hereby authorize the veterinarian(s) to examine, prescribe for, or treat my pet(s). I authorize the release of medical information on my pet(s), if needed, by other veterinarians, groomers, kennels, or proper authorities. I understand I am responsible for full payment of this account and that Professional fees are due at the time services are rendered. A deposit may be required for certain medical treatments. If assistance is ever needed for collection, I know that extra fees will be added to the balance, plus legal interest, and that the total amount will be my obligation.

Signature of Owner

____/____/____
Date