San Dimas Animal Hospital
CLIENT INFORMATION

Thank you for giving us the opportunity to care for your pet(s). So that we may become better acquainted. All the information provided is confidential. Please complete the following:

CLIENT INFORMATION:

Date _____

*Email _____ @_____
* I agree to be notified by TEXT MESSAGE for any appointments or reminders: _____(signature)
* I agree to give my consent to San Dimas Animal Hospital to use my or my pet's images on social media via facebook, website, pinterest & twitter:_____(signature)

*Name_____ Spouse's Name_____

*Address_____*City_____ *State _____ *Zip _____

*Cell Phone #1 (_____) _____ Cell Phone #2 (_____)_____

Work Phone (_____)_____ Place of Employment_____

*Best time to reach you _____ * Driver's License # _____

Date of Birth _____

ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED

Please indicate choice of payment [ ] Cash/Check [ ] Visa/Master Card [ ] AAMEX [ ] Discover [ ] Debit [ ] Care Credit [ ]

How did you become aware of our clinic? [ ]Drove by [ ]Previous Client [ ]On Line: Google/yelp/website/social media [ ] Referral [ ] Other _____

Personal Recommendation (whom may we thank?) _____

PATIENT INFORMATION

	PET#1	PET#2	PET#3	PET#4
*NAME OF THE PET				
*BREED OF THE PET				
*DATE OF BIRTH OF THE PET				
*COLOR OF THE PET				
*Female or Male & Spayed or Neutered				
YOUR DOG'S VACCINATION HISTORY (Approximate date of last vaccine)				
*RABIES				
*DHLP PARVO CORONA				
*BORDETELLA (KENNEL COUGH)				
*LYME DISEASE				
*GIARDIA				
FECAL (STOOL SAMPLE)				
HEARTWORM TEST/PREVENTION				
FLEA PREVENTION				
YOUR CAT'S VACCINATION HISTORY (Approximate date of last vaccine)				
*RABIES				
*FELINE DISTEMPER, RHINO (FVRCP)				
*LEUKEMIA VACCINE				
*FIP				
FECAL (STOOL SAMPLE)				
LEUKEMIA TEST, FELINE AIDS TEST				
HEARTWORM TEST/PREVENTION				
FLEA PREVENTION				

Any previous illness or surgeries? _____ Is your pet on any special diet? _____
Any allergies to vaccinations or medication? _____ Which ones? _____

In the event any balance due hereunder is not paid at the completion of the visit/hospital stay, the undersigned agrees to pay all costs including said unpaid balance, monthly billing and finance charge.

*Owner Signature_____ *Date_____
* required information