



Welcome To Our Practice

Client Information

Owner's Name (Mr/Mrs/Ms/Dr) _____

Spouse/Secondary Owner (Mr/Mrs/Ms/Dr) _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Business Phone _____

Spouse Employer _____ Business Phone _____

If you would like to join our email list and receive monthly updates, pet care tips & vaccination reminders, please give us your email address: _____ @ _____

How did you hear about us? Hospital Sign Website Yellow Pages Advertisement
Personal referral (whom may we thank?) _____

Driver's License # _____ State _____ D.O.B _____
(Required if paying by check)

Patient Information

| | Pet #1 | Pet #2 | Pet #3 |
|-------------------------|---------------|---------------|---------------|
| Pet's Name | _____ / _____ | _____ / _____ | _____ / _____ |
| Species (Dog/Cat/Other) | _____ / _____ | _____ / _____ | _____ / _____ |
| Breed | _____ / _____ | _____ / _____ | _____ / _____ |
| Color | _____ / _____ | _____ / _____ | _____ / _____ |
| Date of Birth / Age | _____ / _____ | _____ / _____ | _____ / _____ |
| Sex | M / F | M / F | M / F |
| Spayed / Neutered? | Y / N | Y / N | Y / N |
| Last Vaccination Date | _____ / _____ | _____ / _____ | _____ / _____ |

**Do any of the above pets have the following?

- Any known Allergies to medications or previous Vaccination Reactions?
 Prior or Current Medical Conditions/ Illness/ Surgeries (other than routine)
 Current Medications (including heartworm & flea preventatives)

*Please describe _____

Name of previous Veterinarian/Hospital _____

I hereby authorize the veterinarian to examine, prescribe for and medically or surgically treat the above pet(s). If I am unable to be contacted, I further authorize such emergency treatment deemed essential by the staff of Timberlane Pet Hospital & Resort to save my pet's life, unless specifically instructed otherwise. I assume full responsibility for all charges incurred in the care of this animal and understand that all charges must be paid in full at the time the pet is discharged from this hospital or the service is otherwise terminated. Payment can be made by: Cash, Visa or Mastercard, Personal Check, and Care Credit. By signing below I hereby state that I am the owner or authorized agent of the above described animal(s).

Signature_____Date_____

For faster service please fax (813)-754-1670