

Chemstrand Oaks Veterinary Hospital

New Client/ Information Update Form

Owners Last Name: _____ First Name: _____ Spouse (Other) _____

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

Home # _____ Cell #: _____ Work #: _____

Spouse (Other) #: _____ Email: _____

Driver's License Number (For Checks): _____ DOB: _____

How did you become aware of Chemstrand Oaks? Please check all that apply.

- Clinic Sign Other Veterinary Hospital Y E L P Web Site Mailing Organization (i.e.: AAFP, AVMA)
 Yellow Pages Other Internet Site Personal Recommendation (Whom may we thank?)

Patient

Name: _____

DOB or Age: _____

Breed: _____

Color: _____

Sex: MALE FEMALE

Has your Pet been Spayed or Neutered:

 YES NO

Species: CANINE (dog) FELINE (Cat)

Any Known Allergies? YES NO If so list here: _____

Any Diagnosed Injury or Illness? YES NO If so list here: _____

Any Previous Surgeries? YES NO If so list here: _____

What medications is your dog taking (including heartworm prevention): _____

We pledge to do our best to care for your pet's health needs. In return we ask you to accept responsibility for all charges incurred in treatment of your pet and accept that payment is due when services are rendered. Please feel free to ask for an estimate prior to providing services. If at any time you are not satisfied with our service, please let us know. We are happy to answer any question you may have.

Treatment Authorization: I am the owner/ authorized agent for the animal named above, and I am 18 years of age or older. I give permission for the Doctors and Staff of Chemstrand Oaks Veterinary Hospital to examine and treat my pet as I have requested. I understand that medical therapy of any kind involves some risk to my pet, including but not limited to adverse drug reactions, and agree to hold the hospital and its employees harmless in the absence of negligence, in connection with these procedures. I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained. In the event of an emergency I understand that life saving measure will be initiated while an attempt is made to contact me. If I cannot be contacted at the listed numbers, the doctor and staff are directed to make decisions deemed best for my pet. **I understand that payment is due when services are rendered, and I agree to pay for those services rendered.**

Media Release Authorization: Pet owners and their pets are often photographed for use in Chemstrand Oaks Veterinary Hospital promotional materials and publicity efforts. These photographs will be used in publication, print ad, direct mail piece, electronic media (e.g. video, CD-ROM, World Wide Web) or other form of promotion. By selecting yes you release Chemstrand Oaks Veterinary Hospital and all employees from liability for any violation of any personal or proprietary right in connection with such use. _____ YES _____ NO

I have read and understand the foregoing, and agree

Signature _____ Date _____