



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 Yellow Pages Internet

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 can extend credit ONLY through a credit card. We accept Visa, MasterCard, American Express and Debit Cards.

If you pay by check, credit card, or debit card please complete the following.

WE CANNOT ACCEPT CHECKS WITHOUT DRIVER'S LICENSE NUMBER OR SOCIAL SECURITY NUMBER ON FILE.

Driver's License:
State: _____ Number: _____

Social Security 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.

Signature _____ Owner's _____ 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 (Please Circle)	Female	Male	Female	Male	Female	Male
	Spayed	Neutered	Spayed	Neutered	Spayed	Neutered
Length of Time Owned						
How/where did you acquire your pet?						
Microchip #						
Hours spent outside daily						
Heartworm / Internal Parasite Prevention Product Used (Please Circle)	Sentinel	Interceptor Other: _____	Sentinel	Interceptor Other: _____	Sentinel	Interceptor Other: _____
	Heartguard	_____	Heartguard	_____	Heartguard	_____
Is this product used continuously, all year?	Yes	No	Yes	No	Yes	No
Flea / Tick Prevention Product Used (Please Circle)	Frontline Plus	Advantix Other: _____	Frontline Plus	Advantix Other: _____	Frontline Plus	Advantix Other: _____
	Frontline Topspot	_____	Frontline Topspot	_____	Frontline Topspot	_____
Is this product used continuously all year?	Yes	No	Yes	No	Yes	No
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 here.)

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:
