Wadsworth Animal Hospital

Client Information

Owner's Name_____Co-Owner_____

Address_____

City_____State_____Zip_____

Owner's Primary Phone Number_____Home____Cell____Work____

Owner's Alternate Phone Number_____Home____Cell____Work____

Co-Owner's Primary Phone Number_____Home____Cell____Work___

Co-Owner's Alternate Phone Number_____Home____Cell____Work____

E-Mail Address_____

Referral Program: How did you hear about our hospital? (Friend, Drive-by, Area DVM, Internet, Rescue etc.)
*If it was a friend, please provide a name so we may thank them.
_____

Methods of Payment Accepted: Cash, Check, Credit Card
We will gladly prepare a written estimate if you so desire. Please ask the doctor. Professional fees are due at the time services are rendered. A deposit may be required before services are provided.

Please Initial: _____Date:_____

1. Pet's Name_____Birthdate_____Sex M/F Spay/Neutured Y/N

   Breed_____Color_____

2. Pet's Name_____Birthdate_____Sex M/F Altered Y/N

   Breed_____Color_____

3. Pet's Name_____Birthdate_____Sex M/F Altered Y/N

   Breed_____Color_____

Please Read

I understand every effort will be made to achieve a successful outcome and to provide for all possible safety, in care and handling. I hereby authorize this hospital to receive, prescribe for, treat or perform surgery upon the pet(s) listed as owned by me and additional pets I present. **Furthermore, I agree to pay fees at the time services are rendered.**

Signature____Date____________________