CHESAPEAKE ANIMAL HOSPITAL

CLIENT INFORMATION

OWNER _____
LAST FIRST SPOUSE/PARTNER

ADDRESS _____
STREET CITY ST ZIP

TELEPHONE _____
CELL WORK HOME

EMAIL ADDRESS _____ DRIVER'S LIC # _____

EMPLOYER _____
NAME ADDRESS

EMERGENCY CONTACT (other than yourself)

_____
NAME (relationship) PRIMARY PHONE

HOW DID YOU HEAR ABOUT US:
Please circle one: Sign, Internet, Other: _____ Friend: _____

PATIENT INFORMATION

NAME _____ BREED _____ COLOR _____

SEX _____ NEUT/SPAY BIRTHDATE _____

PLEASE EMAIL VACCINATION AND RECORDS TO CHESAPEAKEANIMALHOSPITAL@GMAIL.COM OR WE WILL BE HAPPY TO CONTACT YOUR PREVIOUS VETERINARY CLINIC FOR RECORDS PRIOR TO YOUR APPOINTMENT.
MAY WE RELEASE VACCINE INFORMATION CONCERNING YOUR PET TO BOARDING, KENNELS, GROOMERS AND REFERNCE CHECKS? ☐ YES ☐ NO

DOES YOUR PET HAVE ANY ALLERGIES TO ANY MEDICATIONS OR VACCINES? ☐ YES ☐ NO
LIST: _____

MEDICATIONS CURRENTLY TAKING INCLUDING HEARTWORM/FLEA PREVENTION:

LIST:_____

MAY WE POST PHOTOS OF YOUR PET ON SOCIAL MEDIA? ☐ YES ☐ NO

By signing this form, I declare that the above information is correct and current to the best of my knowledge. I am the owner or responsible party for the patient named above, and I agree to pay for all examinations, treatments, medications and other services rendered to the patient at the time they are performed. Returned checks for any reasons will incur a fee of $50.00 plus any statutory fees allowed by law.

We accept the following forms of payment:
CASH, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, AND CARE CREDIT

_____ _____
OWNER/AGENT/RESPONSIBLE PARTY DATE