

# LAFAYETTE ANIMAL HOSPITAL

## Patient and Client Information Sheet

*Thank you for giving Lafayette Animal Hospital the opportunity to care for your pet. So that we may become better acquainted, please complete the following:*

**Mr.**  
**Mrs.** **Owner:** \_\_\_\_\_ **Spouse:** \_\_\_\_\_  
**Dr.** Last First Last First  
**Ms.**

**Children:** \_\_\_\_\_  
First Names

**Address:** \_\_\_\_\_  
Number/Street City State Zip

**Primary Phone:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_ **Other Phone:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**Place of Employment:** \_\_\_\_\_  
Employer/Title Address

**Spouse:** \_\_\_\_\_  
Employer/Title Address

**If necessary, may we call you at work?** [ ] Yes [ ] No

**How did you become aware of our hospital?**

[ ] Yellow Pages [ ] Website [ ] Internet [ ] Hospital Sign [ ] Other

[ ] Personal Recommendation (Whom may we thank?) \_\_\_\_\_

**Please indicate choice of payment:** [ ] Cash [ ] Check [ ] Visa/Mastercard/AmEx

**Pet Information:** Name: \_\_\_\_\_ [ ] Canine [ ] Feline Breed: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Color: \_\_\_\_\_ Sex: M / F Altered?: Y / N

Any prior illness, surgery, or known drug allergies? \_\_\_\_\_

Last Dog or Cat booster vaccine date: \_\_\_\_\_ Rabies: \_\_\_\_\_

*I hereby certify that I am over the age of 18. I understand that all fees are due at time of service, that additional charges apply for returned checks, and that accounts submitted for collection are subject to further charges and costs.*

**Owner Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_