



Quail Corners Animal Hospital & 24 Hour Emergency Care

Client Information

Salutation Mrs. Ms. Mr. Dr.

Salutation Mrs. Ms. Mr. Dr.

Your Full Name _____ Spouse/Co-Owner Full Name _____

Home Phone _____ Home Phone _____

Cell Phone _____ Cell Phone _____

Address _____

City _____ State _____ Zip _____

E-mail Address _____ E-mail Address 2 _____

Pet Information

Pet's Name _____ Dog <input type="checkbox"/> Cat <input type="checkbox"/> Breed _____ Age/Date of Birth: _____ Color _____ Sex: M <input type="checkbox"/> F <input type="checkbox"/> Neutered/Spayed? No <input type="checkbox"/> Yes <input type="checkbox"/> Is your pet up to date on its Rabies Vaccine? Yes <input type="checkbox"/> No <input type="checkbox"/> Is it up to date on other vaccines? Yes <input type="checkbox"/> No <input type="checkbox"/>	Pet's Name _____ Dog <input type="checkbox"/> Cat <input type="checkbox"/> Breed _____ Age/Date of Birth: _____ Color _____ Sex: M <input type="checkbox"/> F <input type="checkbox"/> Neutered/Spayed? No <input type="checkbox"/> Yes <input type="checkbox"/> Is your pet up to date on its Rabies Vaccine? Yes <input type="checkbox"/> No <input type="checkbox"/> Is it up to date on other vaccines? Yes <input type="checkbox"/> No <input type="checkbox"/>
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Is there another veterinary hospital that you regularly use? Yes No

If so, which: _____ Or First Visit to ANY hospital

Do you give Quail Corners Animal Hospital permission to share your pet's medical record, including doctor's medical notes, imaging, laboratory diagnostics, surgical reports or vaccines, etc. with the veterinary hospital listed above? Yes No

Do you give us permission to use your pet's photo for marketing purposes? Yes No

How did you learn about our hospital? Referred By Whom? _____ Other _____

Payment MUST be received at the time services are rendered. If you have financial concerns, please ask to speak with someone before we examine your pet so that we can discuss your options. Thank you.

- If your pet is to be hospitalized or require treatment, a deposit of the low end of the estimate range will be required with full payment at time of discharge.
- We make every effort to stay within your estimate range. However, due to the unpredictable nature of treatment and response, we cannot guarantee the estimate.
- Checks will be taken electronically only. We do not accept held checks as payment.

By signing below, I agree I have read this form completely, I am 18 years or older and I am the responsible party for this animal.

Owner/Agent _____ Date _____