Helena Veterinary Service
PATIENT AND CLIENT INFORMATION SHEET

Office Use Only

Client # ____________

Staff Initial ____________

Thank you for giving our hospital the opportunity to care for you and your pet. So that we may become better acquainted and maintain proper medical records as required by law, please complete the following.

Today's Date: ______ / ______ / ______

Mr. / Mrs. / Dr. / Ms. ______________________________ Spouse ______________
Last *First* *Initial*

Mailing Address ____
Street *Apt* *City* *State* *Zip*

Home Phone ____________________ Email ____________________

Place of Employment ______________________________ Phone ______________

Address ____
Street *Apt* *City* *State* *Zip*

Spouse's Employment ______________________________ Phone ______________

Address ____
Street *Apt* *City* *State* *Zip*

If Necessary, May we Call You at Work? ❑ Yes ❑ No Additional Phone Numbers ______________

Name of other caregiver or pet sitter ______________________________

How did you **First** Become Aware Of Our Hospital?

❑ Yellow Pages ❑ Personal Recommendation - Who May We Thank? ______________

❑ I Was A Client ❑ Veterinarian (Name) ______________ (*If you have been referred to our hospital by another doctor to treat a specific condition, we can only treat that condition. You must return to your regular veterinarian for all future medical problems. This is an ethical necessity.)*

❑ Outdoor Sign ❑ Other ______________

❑ Previous Veterinarian from whom we can obtain records ______________

So that we are able to suit your individual needs - which do you feel most applies to you. These questions are optional and will not affect the quality of care offered to you or your pet.

Check One:

❑ I want the best medical care available for my pet; please recommend anything that you feel is necessary for good health.
❑ I want the best medical care for my pet, but there is a limit to what I am able to have done.
❑ I want you to perform only the services that I request.

Check One:

❑ I want to learn about pet health care, please explain in detail what has been done for my pet or what is needed.
❑ I would prefer you summarize what has been done for my pet or what is needed.
❑ I want my pet healthy, but don't need to know what has been done.

Check One:

❑ I prefer to be present when my pet is examined and treated.
❑ I would rather not see my pet examined and treated.

-- OVER --

Would you like us to keep you informed about procedures to lengthen your pets life? And provide improved quality of life? ❑ Yes ❑ No

What is the best time to reach you at home? ______________________

PET INFORMATION

	Pet "A"	Pet "B"	Pet "C"
NAME			
SPECIES (Dog, Cat, Bird, Etc.)			
BREED			
COLOR			
DATE OF BIRTH			
SEX (MALE/FEMALE)			
ALTERED (YES / NO)			
VACCINATIONS/DATE			

SPECIAL DIETS, MEDICATIONS, ILLNESSES, ALLERGIES OR SURGERIES WE SHOULD BE AWARE OF:

Animal's/Pet's Name:

All fees are due when services are rendered. A deposit is required on all hospitalized pets and the balance is due when your pet is released from the hospital. We do not have a billing system due to the high cost involved in maintaining our hospital. You must be over eighteen years of age to authorized treatment. Please indicate your choice of payment. To pay by check, we ask that you have a driver's license, a check guarantee card and a major credit card. Thank you.

❑ Cash ❑ Check ❑ CARE Credit ❑ Mastercard/Visa ❑ Pet Insurance

Mastercard/Visa #______________________ Driver's License # __________________ Check Guarantee # __________________

I have read and understand your Financial Policy given to me by the receptionist.

Client's Signature____

I understand that should I default on payment of my account and collection agency services are required, all costs of collections, including attorney's fees will be added to the balance of my account.

____

Responsible Party Date Staff Member Date

Thank you for giving us the opportunity to serve you