Crystal Mountain Animal Hospital

Client/Patient Information Sheet

Your Name _____

Spouse/significant other _____

Email address: _____

Address: _____

City, State: _____ Zip code: _____

Cell Phone: _____ Other phone:_____

Pet's Name _____ Date of Birth _____

Color and markings_____

Species (dog/cat)_____ Breed _____
Neutered (Male) Spayed (Female) _____
Microchipped? _____ Microchip # (if known)_____

How did you hear about us?_____

If referred, name:_____

Please list veterinary facilities where we may acquire previous medical history:

_____

_____

_____

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Full payment is required at the time services are provided. I understand that the hospital staff will provide an estimate of current and anticipated charges anytime I request one.

By signing below, I am requesting that veterinary care be provided for pets presented by me and agents. I understand that I am responsible for all services provided.

An appointment will reserve 30 minutes of time for your Pet's exam and consultation.

If you change or cancel your appointment you must give us at least 24 hours' notice to avoid a $50.00 missed appointment fee, and to receive the $1.00 new client exam fee if applicable.

_____ _____

Signature **Date**

_____

Print Name