Island Pet Hospital

Client and Patient Information Sheet

So that we may better serve your needs, please complete the following form entirely.

Social Security # & Driver's License is required should your account be sent to collections.

Owner's Name _____ Social Sec. # _____

Spouse's Name _____ DL # _____ St._____ Exp____

Street Address _____ Home Phone _____

City/Sate/Zip _____ Cell Phone _____

Employer _____ Work Phone _____

Email Address _____

How did you hear about us?

☐ Internet ☐ Phone Book ☐ Web-Site ☐ Walk/Drive by

☐ Friend _____ ☐ Other _____

Pet Information

	Name	Breed	Color	Sex	Spayed or Neutered?	Age/DOB	Microchip?
1					Yes No		Yes No
2					Yes No		Yes No
3					Yes No		Yes No

PAYMENT IS DUE IN FULL AT THE TIME SERVICES ARE RENDERED

We gladly accept Cash, Mastercard, Visa, Amex, Discover, and CareCredit

Please sign the following authorization for treatment:

I hereby authorize the staff of Island Pet Hospital to render any treatment which is deemed necessary to my pet(s) health while in custody of the hospital. I understand that in the event of any unusual or emergency circumstances, the staff will make every attempt to contact me or my designated representative before, if time permits, proceeding with treatment. *I understand that I will be financially responsible for all emergency procedures including the Treatment Plan and/or Estimated Charges provided to me in person or over the telephone. A 1.5% Monthly or 18% Annual Interest fee will be charged on any outstanding balance after 30 days, unless prior arrangements have been made. Should this account be sent to collection, I understand that I will be responsible for any service, collection, and/or legal fees. I understand that professional fees are to be paid at the time of release and a deposit may be required.*

_____ _____

Signature of Owner, or Person(s) presenting pet Date