Labahn Veterinary Hospital

NEW CLIENT INFORMATION

Owner: _____

Address: _____
STREET CITY STATE ZIP CODE

Phone: _____ Phone: _____

Email: _____

We value your personal information. Your email will only be used for notifications from Labahn Veterinary Hospital.

Employer: _____ Phone: _____

Owner Date of Birth: _____ SSN#: _____ Driver License #: _____

*You authorize us to speak to this person about your pets care in the event we cannot reach you.

Spouse/Co-Owner: _____ Phone: _____

What social media platforms do you use? ___Facebook ___Google ___Other:_____

How did you hear about us? ___Family/Friend ___Website ___Google/Online Search ___Driving/Walk In

If you were referred by a client, please tell us so we can say thank you. _____

NEW PATIENT INFORMATION

Pet's Name: _____ ___Dog ___Cat

Breed: _____ Color: _____ Birthday/Age: _____

Sex: ___ MALE ___ NEUTERED / ___ FEMALE ___ SPAYED

Previous Health Issues: _____

Name/Number of Previous Veterinarian: _____

Pet's Name: _____ ___Dog ___Cat

Breed: _____ Color: _____ Birthday/Age: _____

Sex: ___ MALE ___ NEUTERED / ___ FEMALE ___ SPAYED

Previous Health Issues: _____

Name/Number of Previous Veterinarian: _____

We love social media! We would like your consent to share your pet's image on our social media and website.
Your full name and personal information will never be used. ___Yes, please make my pet a star! ___No thank you, my pet is shy.

If cancelling a surgical appointment, we ask for a 48 hour notice. A late cancellation (or frequent cancellations) may result in a fee applied to your account.

Current vaccinations are required by Labahn Veterinary Hospital before we admit any animal for any reason. These measures are taken to protect the well-being of all animals within our hospital.

Treatment Consent: I hereby authorize the veterinarian to examine, prescribe for or treat the above described pet (s). I assume responsibility for all charges incurred in the care of this animal. I understand that payment is always due in full at time of service. I recognize that financial concerns should be discussed prior to exam and treatment. For your convenience we accept Visa, MasterCard, American Express, Discover, CareCredit, Scratch pay, cash and in-state checks with proper identification. Please stop at the reception desk to review and pay for services.

I confirm that the above information is correct and that I am the owner or legally authorized agent of the patient(s) listed above:

_____ _____

Signature: Date:

Revised 9/18/2019