Crossroads Animal Hospital

Thank you for choosing Crossroads Animal Hospital for the care of your pet.

Please assist us by completing this form.

CLIENT INFORMATION

Name: _____ Spouse: _____

Address: _____ City: _____ State: ___ Zip: _____

Phone: _____ Cell: _____ Work: _____ Spouse: _____

E-mail: _____ Drivers License #_____

Name of anyone other than you that you authorize to order/approve treatment or obtain medical information: _____

_____

PATIENT INFORMATION

	Pet #1	Pet #2	Pet #3
NAME			
BREED			
DATE OF BIRTH / AGE			
COLOR			
SEX			
SPAYED / NEUTERED?			
ALLERGIES			
SPECIAL DIET?			

Previous veterinarian where medical records may be obtained: _____

How did you choose us for your pet's care? ☐ Location ☐ Yellow pages ☐ Website ☐ HEB Receipt

☐ Referral - who may we thank? _____

May we use a picture of your pet in future postings on our website or Facebook page? ☐ Yes ☐ No

PLEASE LIST ANY SYMPTOMS OR PROBLEMS YOU'VE NOTICED WITH YOUR PET

_____

_____

_____

_____

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet(s). ALL unpaid accounts are subject to a 35% collection fee. By signing, I agree to the terms of payment on my account, and any NSF fees.

Signature of client responsible for pet(s) _____

For your convenience, we accept Cash, checks, Visa, Mastercard, Discover, and American Express. Payment is due at time of service.