Arlington Heights
VETERINARY HOSPITAL

Date:_______________ _

Primary Client:

Client's Legal First Name:__________________ Client's Legal Last Name:__________________

Date of Birth:______________________ Driver's License Number:________________________

Social Security Number:_________________ Street Address:_____________________________

City:________________________ State:_______________________ Zip code:________________

Primary Phone:___________________________ Secondary Phone:_________________________

May we contact you via text? Y or N Email Address: ___________________________________

Employer:___________________________ Work Phone:________________________________

Secondary Client/ Spouse:

Client's Legal First Name:__________________ Client's Legal Last Name:__________________

Date of Birth:______________________ Driver's License Number:________________________

Social Security Number:_________________ Street Address:_____________________________

City:________________________ State:_______________________ Zip code:________________

Primary Phone:___________________________ Secondary Phone:_________________________

Emergency Contact:

Name:___________________________________ Phone:___________________________________

Preferred Pharmacy:

Name of Pharmacy:_________________________ Phone:________________________________

To the best of my knowledge, all the above information is true and accurate. I accept full legal and financial responsibility for all services rendered. I understand that payment is due at time of service. I understand that if my account becomes past due, I will be responsible for all fees, interest charges, late charges, and all costs of collection, including, but not limited to, attorney's fees and court costs. Additionally, no goods or services, including emergency services, will be rendered until my balance is paid in full. My signature on this form authorizes the release of any information relating to claims filed on my behalf.

Signature:____ Date:______________________

Patient Information

Patient's Name:____________________________

Patient's Date of Birth or Age:________________

Coat Color:________________________________

Species: Dog or Cat (Circle One)

Breed:__________________

Patient's Gender:

Male

Neutered Male

Female

Spayed Female

Patient's Name:____________________________

Patient's Date of Birth or Age:_______________

Coat Color:_______________________________

Species: Dog or Cat (Circle One)

Breed:_________________

Patient's Gender:

Male

Neutered Male

Female

Spayed Female

Patient's Name:____________________________

Patient's Date of Birth or Age:_______________

Coat Color:_______________________________

Species: Dog or Cat (Circle One)

Breed:_________________

Patient's Gender:

Male

Neutered Male

Female

Spayed Female

If you have more than 3 pets please fill out another form and send to us, thank you

Please list any additional information we need to know about your pet(s) below:

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