BRAELINN ANIMAL HOSPITAL

Client/Patient Information

Thank you for giving us the opportunity to care for your pet. Please help us better meet your pet's needs by taking a few moments to fill out both sides of this information sheet.

Name:______________________ Spouse/Other:______________________

Address:______________________________ Apt. #:__________

City, State:______________________________ Zip:__________

Home #:______________________ Cell#:______________________

E-mail:____

Place of Employment:______________________ Work #:__________

Spouse's Place of Employment:______________________ Work #:__________

In case of emergency, please call:______________________ Phone#:__________

Referrals are the greatest compliment our hospital can receive. We would like to acknowledge and thank those who refer new clients to us. Please help us do so by telling us how you heard about our hospital:

- ❑ Individual, someone we may thank?______________________
- ❑ An Organization? If so, which one?______________________
- ❑ Phone/Online Directory ❑ Hospital Sign ❑ Other? Please state:__________

*** Due to state law and insurance requirements, ALL patients MUST be current on his/her Rabies Vaccine. Vaccinations will be updated at the time of hospitalization or boarding if they are not current.

*** To help prevent the spread of infectious disease, ALL hospitalized and boarded pets must be current on all required vaccines and free of both internal and external parasites.

Braelinn Animal Hospital will occasionally record photos, video, and audio to publish on various media sites for the purpose of education, marketing, and publicity. Please sign in this box below if you authorize Braelinn Animal Hospital to record, own, publish, and republish information about me/my pet(s) and reproductions of my likeness and my voice. By signing, you are also indicating that you are 18 years of age or older.

*****I release Braelinn Animal Hospital from any and all claims that might arise from the use of these images and recordings**

Signature:______________________________ Date:__________

Signature:______________________________ Date:__________

BRAELINN
ANIMAL HOSPITAL

Pet Information

PET #1:

Name: ____________________

Sex: ❑ Female Spayed? ❑ Yes ❑ No ❑ Male Neutered? ❑ Yes ❑ No

Breed: ____________________

Birthday/Age: ____________________

Color/Description: ____________________

Date of Last Vaccines: ____________________

Hospital Where Given: ____________________

Prior Illnesses/Surgeries: ____________________

Do You Consider Your Pet Part of Your Family? ____________________

Reason for Today's Visit: ____________________

Do we have your permission to request a transfer of records? ____________________

PET #2:

Name: ____________________

Sex: ❑ Female Spayed? ❑ Yes ❑ No ❑ Male Neutered? ❑ Yes ❑ No

Breed: ____________________

Birthday/Age: ____________________

Color/Description: ____________________

Date of Last Vaccines: ____________________

Hospital Where Given: ____________________

Prior Illnesses/Surgeries: ____________________

Do You Consider Your Pet Part of Your Family? ____________________

Reason for Today's Visit: ____________________

Do we have your permission to request a transfer of records? ____________________

****If you have additional pets and would like to fill out information for them at this time, please let one of our staff members know. Thank You.**