CLIENT INFORMATION

Responsible party: Secondary contact:

Address:

City: State: Zip:

Primary Contact #: Secondary #: Alternate #:

Referred to us by: Email address:

Preferred mode of correspondence: Y or N E-Mail _____ Text_____ Phone ____ U.S. Mail____

In order to write checks we need your D.L.#:

Can we have your permission to use photos of you and your pets taken here? Yes ☐ No ☐

Would you like information on our Pet Portal & on-line pharmacy? Yes ☐ No ☐

AUTHORIZATION:

I hereby authorize the Animal Hospital of Sebastopol to examine, prescribe for, and treat my animals. I assume responsibility for all charges incurred in the care of my animals. I also understand that these charges are due at the time services are rendered and that a deposit may be required for surgical treatment.

Signature of responsible party:_____ Today's Date:_____

Printed name:_____ Owner D.O.B. for prescription drugs:_____