ARROWHEAD ANIMAL HOSPITAL

Grant J. Mayne, DVM Darryl H. Coleman, DVM K. Patrick Rains, DVM

Client Information Sheet

Welcome and thank you for choosing Arrowhead Animal Hospital.
We are dedicated to providing the best care possible for your treasured pet(s) in a clean and friendly environment.

REGISTRATION

Please take the time to fill in this form completely.

Date________________

Owner Last Name ________________________________ First Name ________________________________

Home Phone __________________ Cell Phone ___________________ Work Phone ____________________

E-Mail Address ____ Birth Date ____________________

P. O. Box Number ______________ Town _________________________________ Zip ______________

Physical Address _______________________________________ Town _____________________________

Co-Owner Last Name ______________________________ First Name ________________________________

Home Phone __________________ Cell Phone ___________________ Work Phone ____________________

How did you learn about our clinic? ☐ Yellow Pages ☐ Recommendation

☐ Sign ☐ Other _________________________________

Number of pets: Dogs ______ Cats _____ Other (specify) __________________________________

If recommended, by whom? ____

Reason for visit ____

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, or treat any of my pet(s). I assume responsibility for all charges incurred in the care of all my pet(s). I also understand that these charges will be paid at the time of visit and that a deposit may be required for surgical treatment.

Signature of Owner ____ Date________________________

Preferred method of payment ☐ Cash ☐ Check ☐ Credit Card ☐ Other ____________________