

ARLINGTON HEIGHTS ANIMAL HOSPITAL

OWNER INFORMATION			
Owner's Last Name:	First:	Co-Owner/Spouse:	
Mailing Address:			
City:	State:	Zip:	Email:
Home Phone:	Owner's Cell Phone:	Owner's Work Ph:	
Owner's Employer:		Address:	
Driver's License Number:	County:	<input type="checkbox"/> Cook <input type="checkbox"/> DuPage <input type="checkbox"/> Lake <input type="checkbox"/> Kane <input type="checkbox"/> McHenry <input type="checkbox"/> Other:	
Co-Owner/Spouse's Employer:		Address:	Phone:
EMERGENCY CONTACT AND/OR AUTHORIZED AGENT			
(This is a person whom you authorize to make decisions and execute consent and authorization for the pet named on this form.)			
Contact Name:	Phone Number:	Relationship:	
PATIENT INFORMATION			
Pet's Name:		<input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other:	Date of Birth:
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Neutered <input type="checkbox"/> Female <input type="checkbox"/> Spayed	Breed:	Color:
List Any Previous Medical Conditions:			
Allergies to vaccinations or medications? <input type="checkbox"/> No <input type="checkbox"/> Yes If so, what?			

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the care of the animal.

All professional fees are due at the time services are rendered. Due to the high cost of bookkeeping and billing, positively no charging allowed except through Visa, MasterCard, Discover, American Express or Care Credit. (Applying for Care Credit only takes a few minutes and there is no fee to apply.) We also accept cash or check/debit card. We do not accept post-dated checks and will not hold checks for any period of time. There will be a \$35.00 administration/bank fee for any returned check.

I have completed this form to the best of my knowledge and have read the financial policy and agree to the terms.

Client Signature	Date
<i>** I authorize the release of my phone number, name and/or vaccine information to the Humane Society, County Officials, or individuals that have identified my animal by a rabies vaccine tag and wish to contact me to return my pet. **</i>	
<input type="checkbox"/> Agree: Initial _____	<input type="checkbox"/> Disagree: Initial _____

HOW DID YOU HEAR ABOUT US?

INTERNET SEARCH

Yelp Google

Other _____

ADVERTISEMENT

Arlington Hts. Almanac Church Bulletin

FAMILY/FRIEND

*Refer a friend and receive \$20.00 AHAH account credit.

Thanks for giving us the opportunity to serve you.