Client #:___________

McFarland Animal Hospital

Client/Patient Information Form

Thank you for giving us the opportunity to care for your pet. Please print and complete all information.

Name____

Address____

City_________________________ State___________ Zip_________

Home Phone_________________ Cell Phone__________________

Work Phone_________________ Employer___________________

Occupation____

Email Address_______________________________________

Who else is responsible for your pets?

Name____

Address____

City_________________________ State___________ Zip_________

Home Phone_________________ Cell Phone__________________

How did you first hear about us?

____Hospital Sign ____Yellow Pages ____Bucky Book ____Newspaper

Internet: ____Google ____Bing ____Yellow Pages ____ Our Website ____Other

____Referral (whom may we thank?) ______________________________

Full payment is required at the time services are provided. At your request, we will provide you with a written estimate of fees for any hospital treatment, emergency care, surgery or hospitalization. You are responsible to notify us if any of the above information changes.

I have read any understood the financial information above and agree to these terms. I request that veterinary care be provided for pets presented by my agents or me. I assume financial responsibility for services rendered.

____ _______________

Signature Date