

# Lone Oak Animal Clinic

*Thank you for giving us the opportunity to care for your pet(s).*

*So that we may become better acquainted, please complete the following and provide your driver's license:*

## CLIENT INFORMATION

Today's Date \_\_\_\_\_

Owner's Name \_\_\_\_\_ Spouse/Co-Owner's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Spouse/Co-Owner's Phone \_\_\_\_\_

May we text you: Yes No Ph# \_\_\_\_\_

Place Of Employment \_\_\_\_\_ Email Address \_\_\_\_\_

## ALL FEES ARE DUE AT THE TIME THE SERVICES ARE RENDERED

**Please indicate choice of payment.** Cash / Check Visa ☐ MasterCard ☐ Discover ☐ Care Credit ☐

(Please be aware there is a 3% surcharge for credit cards, this does not apply to debit cards.)

How did you become aware of our clinic? Drove by\_\_\_ Internet Search\_\_\_ Web Site\_\_\_ Another Client\_\_\_ Other \_\_\_\_\_

Personal Recommendation (Whom may we thank?) \_\_\_\_\_

Patient Information	PET # 1	PET # 2	PET # 3
NAME			
IF DOG LIST BREED			
IF CAT LIST SHORT OR LONG HAIR			
DATE OF BIRTH or Approx. Age			
COLOR			
SEX : M/F SPAYED OR NEUTERED?			
DATE OF LAST VACCINES:			
PLACE OF LAST VACCINES:			
Any allergies to vaccinations or medications?	Yes / No	Yes / No	Yes / No
Is your pet on any special diets or medications?	Yes / No	Yes / No	Yes / No
Any previous serious illnesses or surgeries?	Yes / No	Yes / No	Yes / No

Do you give us permission to call other clinics to obtain your pet(s) medical records?

Yes No

Our pet(s) is: Member of our family € Child's pet Backyard pet

**\*\*Please be aware that we are not staffed 24 hours a day. If you wish to have 24-hour care, we are happy to refer you to a facility with 24 hour care.\*\***

Signature: \_\_\_\_\_