



Client/Owner Information

Thank you for giving us the opportunity to care for your pet. Please help us to meet your needs better by taking the time to complete this information sheet.

Today's Date: _____

First Name: _____ Last Name: _____ Name of Spouse or Other: _____

Address: _____ Apt/Unit#: _____

City: _____ State: _____ Zip Code: _____ County: LAKE/COOK/MCHENRY/OTHER (**circle one**)

Email Address (for Hospital use only): _____

· Email is used for annual vaccine reminders, in addition to pertinent hospital communication

Primary phone number (home/cell/work): _____ Contact Name: _____

Secondary phone number (home/cell/work): _____ Contact Name: _____

PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED

All Creatures Animal Hospital accepts cash, personal checks, Visa, MasterCard, Discover, American Express and Care Credit for payments of service. I assume responsibility for all charges incurred in the care of this (these) animal(s). I also understand that these charges are to be paid at the time of release unless other arrangements are made in advance, and that a deposit may be required for treatment and/or surgery.

NO SHOW & LATE CANCELLATION POLICY

I understand that should I fail to show up for my scheduled appointment, or cancel with less than 24 hours' notice, my appointment will be considered a no-show/late cancellation. Due to the time reserved, a deposit will be required before any future appointment can be rescheduled.

I acknowledge that I have read and understand the above policies.

Owner Signature

Date

PLEASE CONTINUE TO THE REVERSE SIDE OF THIS SHEET TO COMPLETE THIS FORM



Patient Information

Pet Name	Species (feline/ canine)	Breed	Male/Female Neutered/ Spayed	Approx. Date of Birth	Microchip (yes/no)

Has your pet been treated for any illness in the past year? **YES** ___ **NO** ___

Please specify problem(s), medications(s), diet, etc.....:

Previous animal hospital (if applicable) where records could be obtained if necessary:

Clinic Name: _____ Phone number: _____

RECORDS RELEASE AUTHORIZATION (Optional)

I hereby authorize All Creatures Animal Hospital to release my pet(s) medical records to me or to a designated business or facility such as but not limited to an insurance company, another animal hospital or an emergency facility to whom I have provided All Creatures Animal Hospital's contact information.

Owner Signature

Date

SOCIAL MEDIA PHOTO RELEASE (Optional)

I hereby authorize All Creatures Animal Hospital to use photographs of me and/or my pet, along with our names, on social media. I understand participation is voluntary, and I will not receive compensation or ownership rights for any images used. I release and hold harmless All Creatures Animal Hospital, its employees, and affiliates from any claims related to the use of these photographs. (Medical records remain protected under privacy and confidentiality policies.)

Owner Signature

Date