Client & Patient 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/Unti#: _____

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.

SIGNATUE OF OWNER OR RESPONSIBLE PARTY: _____ DATE: _____

Patient Information

Pet Name	Species (feline/ canine)	Breed	Male/Female Neutered/ Spayed	Approx. Date of Birth	Microchip (yes/no)	Medical Conditions	Medications	Diet/Food Type

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

Has your pet been treated for any illness in the past year? **YES__ NO __**
Please specify problem(s), medications(s), diet, etc.…:

_____

_____

To prevent the spread of infection diseases and parasites, hospitalized animals must be current on all vaccinations and be free of internal and external parasites. I authorize the doctor to provide vaccine and parasite control as needed for my pet.

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

Clinic Name: _____ Phone number: _____

Records Release Authorization

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**

Photography Release

All Creature Animal Hospital has social media sites that often provide us with the opportunity to share photos with the general public. We would like your permission to use photographs of you and/or your pet for this purpose.

I hereby authorize All Creatures Animal Hospital to publish photographs taken of me and/or my pet, and our names, for use on their social media sites. I further acknowledge that my participating is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs. I acknowledge and agree that the publication of any photos confers no rights of ownership or royalties whatsoever. I hereby release and hold harmless All Creatures Animal Hospital from any reasonable expectations of privacy or confidentiality associated with my images (medical records, as always, are protected by privacy and confidentiality policies). I also released All Creatures Animal Hospital, it's employees, and any third parties in the creation of publication of these photographs from liability for any claims by me or any third party in connection with my participation.

_____ _____

Owner Signature **Date**