Tipp City Veterinary Hospital and Wellness Center
... professional care with a loving heart

CLIENT / PET INFORMATION

Welcome to the Tipp City Veterinary Hospital and Wellness Center. Please share some information about you and your pet(s) so we can provide you with exceptional service. Our mission is to provide you with the very best loving, compassionate veterinary health and wellness care from before hello to beyond goodbye.

(PLEASE PRINT)

CLIENT INFORMATION

Name _____ Date _____
(First) (Last)

Driver's License # _____ Soc. Security # _____
(Expiration) *(Optional)*

Address _____
(Street) (City) (State) (Zip Code)

Home Phone _____ Mobile Phone _____
(Area Code) *(Area Code)*

Employer _____ Work Phone _____
(Area Code) *(Ext.)*

Email Address _____

SPOUSE / CO-OWNER INFORMATION *(if applicable)*

Name _____
(First) (Last)

If the contact information is the same as above, skip to the next section.

Address _____
(Street) (City) (State) (Zip Code)

Home Phone _____ Mobile Phone _____
(Area Code) *(Area Code)*

Employer _____ Work Phone _____
(Area Code) *(Ext.)*

Email Address _____

EMERGENCY CONTACT

Name _____
(First) (Last)

Home Phone _____ Work Phone _____
(Area Code) *(Area Code)*

PET INFORMATION

Pet's Name _____ ☐ Dog ☐ Cat ☐ Other _____

Age / Birth Date _____ ☐ M ☐ F Breed _____ Color _____

Altered / Spayed? ☐ Yes ☐ No

Where did you obtain this pet? ☐ Friend ☐ Breeder ☐ Pet Store ☐ Rescue Org. ☐ Other _____

At what age was this pet obtained? _____
(Months/Years)

For what purpose was this pet obtained? ☐ Companionship ☐ Protection ☐ Breeding ☐ Other _____

Diet (pet's food) _____ Treats _____

Describe any:

☐ Prior Illness _____ ☐ Prior Surgery _____

☐ Allergies _____ ☐ Medications _____

Reason for pet's visit today? _____

PRIOR MEDICAL HISTORY *(if applicable)*

Who is your prior veterinarian? _____

City _____ State _____ Phone _____
(Area Code)

May we contact them to obtain a copy of your pet's medical records? ☐ Yes ☐ No

ACKNOWLEDGEMENT

We will gladly prepare a written estimate of service fees if you desire (please ask a staff member). **All professional fees are due at the time services are rendered.** We accept the following forms of payment: cash, personal checks, Visa, MasterCard, American Express, Discover, and Care Credit. Returned checks will be electronically re-presented to your account along with the state allowable fee. Your use of check is your acceptance of this policy. In cases of extensive medical or surgical procedures where full payment may be difficult at discharge, payment arrangement may be established if approved in advance.

By signing below, you acknowledge that you understand our payment policy and verify that all of the information you provided is accurate.

Clients's Signature _____ Date _____