Arlington Heights
VETERINARY HOSPITAL

Date: / /

Full Name: _____ DOB: / / SSN: _____

Address _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

Drivers License#: _____

Employer: _____ Work Phone: _____

Spouse's Name: _____ DOB: / / SSN: _____

Spouse's Employer: _____ Work Phone: _____

Spouse's Cell Phone: _____ Drivers License#: _____

Person To Contact in Case of Emergency: _____ Phone: _____

Nearest Relative: _____ Phone: _____

Address: _____

Email: _____

If email is provided it will not be sold to any third parties, it will only be used to better serve you and your pet. You will only receive information regarding your pet from Arlington Heights Veterinary Hospital. Thank you.

To the best of my knowledge, all of the preceding answers are true and correct. I accept full responsibility for all treatment performed. I understand payment is expected at the time services are rendered. I understand that should my account become past due, I will be responsible for all fees, interest charges, late charges and all cost of collection including, but not limited to, attorney's fees and court cost. My signature on this form authorizes the release of any information relating to claims filed on my behalf.

Signature: _____

(Patient Information Continued on Back)

Patient Information

Patient Name: _____
Species: _____
Coat Color: _____
Birth Date: _____

Sex: (Circle One)
Male
Female
Spayed Female
Neutered Male

Patient Name: _____
Species: _____
Coat Color: _____
Birth Date: _____

Sex: (Circle One)
Male
Female
Spayed Female
Neutered Male

FOR ADDITIONAL PETS PLEASE ASK THE RECEPTIONIST FOR ANOTHER FORM

Any Additional Information we may need about your pet:

_____

_____

_____

_____