



Arlington Heights

VETERINARY HOSPITAL

Date: _____

Account Number: _____

Primary Client:

Client's Legal First Name: _____ Client's Legal Last Name: _____

Date of Birth: _____ Driver's License Number: _____

Social Security Number: _____ Street Address: _____

City: _____ State: _____ Zip code: _____

Primary Phone: _____ Secondary Phone: _____

May we contact you via text? Y or N Email Address: _____

Employer: _____ Work Phone: _____

Secondary Client/ Spouse:

Client's Legal First Name: _____ Client's Legal Last Name: _____

Date of Birth: _____ Driver's License Number: _____

Social Security Number: _____ Street Address: _____

City: _____ State: _____ Zip code: _____

Primary Phone: _____ Secondary Phone: _____

Emergency Contact:

Name: _____ Phone: _____

Preferred Pharmacy:

Name of Pharmacy: _____ Phone: _____

To the best of my knowledge, all the above information is true and accurate. I accept full legal and financial responsibility for all services rendered. I understand that payment is due at time of service. I understand that if my account becomes past due, I will be responsible for all fees, interest charges, late charges, and all costs of collection, including, but not limited to, attorney's fees and court costs. Additionally, no goods or services, including emergency services, will be rendered until my balance is paid in full. My signature on this form authorizes the release of any information relating to claims filed on my behalf.

Signature: _____ Date: _____

Employee's Initials: _____

(Patient Information Continued on the Back)

Patient Information

Patient's Name: _____

Patient's Date of Birth or Age: _____

Coat Color: _____

Species: Dog or Cat (Circle One)

Breed: _____

Patient's Name: _____

Patient's Date of Birth or Age: _____

Coat Color: _____

Species: Dog or Cat (Circle One)

Breed: _____

Patient's Name: _____

Patient's Date of Birth or Age: _____

Coat Color: _____

Species: Dog or Cat (Circle One)

Breed: _____

Please list any additional information we need to know about your pet(s) below:

Patient's Gender: (Circle One)

Male

Neutered Male

Female

Spayed Female

Patient's Gender: (Circle One)

Male

Neutered Male

Female

Spayed Female

Patient's Gender: (Circle One)

Male

Neutered Male

Female

Spayed Female

IF YOU HAVE MORE THAN 3 PETS, PLEASE ASK THE RECEPTIONIST FOR AN ADDITIONAL FORM.