



College Animal Hospital Welcomes you and your fur-family!

First Name: _____ Last: _____

Spouse/Other: _____

Address: _____

Zip: _____ City: _____ State: _____

Phone: Cell Phone (____) _____ Secondary (____) _____

Email: _____

How did you find us? _____

Birth Date (State requirement to dispense controlled drugs): month/day/year _____

 Patient Name: _____

Species: _____ Sex: _____ Neutered/Spayed: ____ Yes ____ No

Breed & Color: _____ Date of Birth or Age: _____

Do you have PET INSURANCE: ____ Yes ____ No. If yes, Type of Insurance: _____

Do you have vaccine history? ____ Yes ____ No. If not, where was your pet last vaccinated _____

Please list any known reactions /allergies (vaccines, meds, food) _____

Previous Medical Problems / History: _____

We apologize for any inconvenience:

We do NOT accept personal checks. We accept all major credit cards and Care Credit. **Initial** _____

I understand that I am responsible for all charges incurred during the treatment of my pet(s). By signing and dating below I state that I am aware of this responsibility and understand all procedures require a deposit (or full payment) at admittance, and that payment is due when services are rendered. I also authorize my pet's picture to be used in social media or on the hospital website.

Signature _____

Print Name _____ Date _____

**Your new home for compassionate,
Personalized professional care!**