



WELCOME!

Companion Animal Hospital

Dr. R. Gilbert Dr. K Gillane



Date: _____

Name

Last

First

MI

Address

Street

City

LA

Zip

Mailing

Phone Number

Cell

Home

Other

Email

Employer

Co-Owner

Name

Phone

Pet Information

Name:

Approx DOB

Species: DOG CAT OTHER

Breed:

Sex: _____ Neutered: Y/N

Color:

Microchipped? Y/N

Previous Vet:

Pet Information

Name:

Approx DOB

Species: DOG CAT OTHER

Breed:

Sex: _____ Neutered: Y/N

Color:

Microchipped? Y/N

Previous Vet:

May we contact your previous vet(s) for records/history on your pets? Y/N Initial: _____

Authorization:

I hereby authorize the veterinarians to examine, prescribe for, or treat the above pets. I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment.

Signature of responsible party:

Method of Payment:

CASH

CHECK

VISA/MC/DISCOVER/AMEX

CARE CREDIT

How did you hear of us?:
