OTTAWA ANIMAL HOSPITAL, LLC

"Where you'll find a warm heart for a cold nose."

Welcome to our practice!

Client Information

Name_____ Spouse/Partner Name_____

Address_____ Apt/Lot # _____ City_____State_____Zip_____

Your Primary Contact Numbers

*Include your **primary** contact number first, then spouse, persons authorized to treat, etc.*

Name	Phone Number	Type *(cell, work, etc)*

Who is authorized to treat your pet in your absence_____

Primary e-mail address for communications_____

We use e-mail for Pet Portal access, newsletters, reminders, and client education. We never sell e-mail addresses.

Your Driver's License Number_____DOB_____/_____/_____

The State of Michigan requires us to report any controlled substances that we prescribe or administer to our patients, therefore we need your date of birth and driver's license number on file.

Your Employer_____ Phone Number ( ) __ __ __ - __ __ __ __

Partner's Employer_____ Phone Number ( ) __ __ __ - __ __ __ __

Patient Information

	Pet #1	Pet #2	Pet #3
Name			
Breed			
DOB/Age			
Color			
M/F; Neutered/Spayed			

Previous Veterinarian_____Phone_____

Do we have a copy of your pets medical history?_____

What is your pet taking for heartworm and flea/tick protection?_____

Additional questions on reverse side.

Does your pet or any members of your household have any allergies?* _____

** During your visit with us, we offer a wide variety of treats to your pet. This may include products containing nuts, wheat, or soy. Please let us know if there are any known allergies.*

How did you first learn about our hospital? We would like to thank any individuals who referred you.

Please circle all that apply.

Hospital Sign Facebook Google Website Friend/Relative/Co-worker Local Business Other

Referred by_____

Record Release

In the event that a request is made for your pet's medical record to be released for any purpose. We would like your permission to release the record as follows: *(Please only check one)*

- ❑ I authorize the release of my pet's medical records in any circumstance without contacting me.
- ❑ I do not authorize release of my pet's medical records unless you get my verbal permission prior.
- ❑ I authorize the release of my pet's medical records in an emergency situation only.
- ❑ Other - Please indicate how you would like us to handle your pet's medical records if a request is made.

Photo Consent

Ottawa Animal Hospital has the right to photograph my pet(s) and to use & publish said photographs for any lawful purpose, including, for example, such purposes as education, publicity, advertising, and web content.

- ❑ I authorize Ottawa Animal Hospital to photograph and publish photos of my pet.
- ❑ I do not authorize Ottawa Animal Hospital to photograph and publish photos of my pet.

Professional fees are due at the time services are rendered.

We accept cash, local checks, Visa, MasterCard, Discover, American Express, and Care Credit.

I agree to be responsible for authorizing procedures and/or paying for services. Any unpaid balance will accrue finance charges monthly and court fees if sent to collections.

_____ _____

Signature *Date*

Statement of Ownership

I certify that I am the true owner and or agent of the above animal(s) and have authorization to consent to treatment if and when it is needed. I understand that by signing this document, I agree to the above terms of service.

_____ _____

Signature *Date*