

CLIENT INFORMATION FORM

**PRIMARY OWNER**  
 NAME: LAST \_\_\_\_\_ FIRST \_\_\_\_\_ TITLE \_\_\_\_\_  
 DATE OF BIRTH \_\_\_\_\_  
 MAILING ADDRESS:  
 STREET ADDRESS \_\_\_\_\_ APT \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIPCODE \_\_\_\_\_  
 CONTACT INFORMATION:  
 HOME \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_ EXT \_\_\_\_\_  
 EMAIL ADDRESS \_\_\_\_\_  
 WHICH IS THE BEST WAY TO CONTACT YOU DURING THE DAY? \_\_\_\_\_  
 WHICH IS THE BEST WAY TO CONTACT YOU AFTER BUSINESS HOURS? \_\_\_\_\_  
 EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
 DRIVERS LICENSE \_\_\_\_\_ EXPIRATION \_\_\_\_\_ STATE \_\_\_\_\_

**SPOUSE/CO-OWNER**  
 DATE OF BIRTH \_\_\_\_\_  
 NAME: LAST \_\_\_\_\_ FIRST \_\_\_\_\_ TITLE \_\_\_\_\_  
 MAILING ADDRESS: (IF DIFFERENT THAN ABOVE)  
 STREET ADDRESS \_\_\_\_\_ APT \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIPCODE \_\_\_\_\_  
 CONTACT INFORMATION:  
 HOME \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_ EXT \_\_\_\_\_  
 EMAIL ADDRESS \_\_\_\_\_  
 WHICH IS THE BEST WAY TO CONTACT YOU DURING THE DAY? \_\_\_\_\_  
 WHICH IS THE BEST WAY TO CONTACT YOU AFTER BUSINESS HOURS? \_\_\_\_\_  
 EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
 DRIVERS LICENSE \_\_\_\_\_ EXPIRATION \_\_\_\_\_ STATE \_\_\_\_\_  
 RELATIONSHIP TO PRIMARY OWNER? \_\_\_\_\_

<p><b>HOW DID YOU HEAR ABOUT US?</b></p> <p><input type="checkbox"/> YELLOW PAGES</p> <p><input type="checkbox"/> DROVE BY HOSPITAL</p> <p><input type="checkbox"/> PERSONAL REFERRAL</p> <p>WHO MAY WE THANK? _____</p> <p><input type="checkbox"/> OTHER _____</p>	<p align="center"><b>EMERGENCY TREATMENT</b></p> <p>In the event of an emergency, do you authorize the treatment of your pet(s), if every attempt made to contact you was unsuccessful?</p> <p>YES _____ NO _____</p> <p align="center">INITIAL _____</p>
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<p><b>PET INFORMATION (LIST ADDITIONAL PETS ON SECOND PAGE)</b></p> <p>NAME _____ SPECIES? _____ DOG CAT</p> <p>BIRTH DATE _____ SEX? _____ MALE FEMALE</p> <p>BREED _____ NEUTERED? _____ YES NO</p> <p>COLOR _____ SPAYED? _____ YES NO</p> <p>MARKING(S) _____ VACCINATED? _____ YES NO</p>	<p align="center"><b>PREVIOUS VETERINARIAN</b></p> <p>_____</p> <p>Would you like your pet's medical history transferred to our hospital?</p> <p>YES _____ NO _____</p>
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I, the undersigned, and owner or authorized agent of the above mentioned pets, do hereby authorize Aloha Anima Hospital to perform such examinations, diagnostic tests and treatments as necessary. I further agree to be financially responsible for all costs for such procedures and treatments. I understand that full payment is due at the time services are rendered. I understand that abandonment of animals does not relieve me of this financial obligation. Failure to pay bills on time may result in billing, finance charges and/or cost of any collection fees incurred.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PET INFORMATION

NAME _____	SPECIES? _____	DOG	CAT
BIRTH DATE _____	SEX?	MALE	FEMALE
BREED _____	NEUTERED?	YES	NO
COLOR _____	SPAYED?	YES	NO
MARKING(S) _____	VACCINATED?	YES	NO

PET INFORMATION

NAME _____	SPECIES? _____	DOG	CAT
BIRTH DATE _____	SEX?	MALE	FEMALE
BREED _____	NEUTERED?	YES	NO
COLOR _____	SPAYED?	YES	NO
MARKING(S) _____	VACCINATED?	YES	NO

PET INFORMATION

NAME _____	SPECIES? _____	DOG	CAT
BIRTH DATE _____	SEX?	MALE	FEMALE
BREED _____	NEUTERED?	YES	NO
COLOR _____	SPAYED?	YES	NO
MARKING(S) _____	VACCINATED?	YES	NO