



# JEFFERSON ANIMAL HOSPITAL EAST

5400 Del Maria Way • Spanish Cove Center • Louisville, KY 40291 • (502) 499-6535



## Client Information

Date: \_\_\_/\_\_\_/\_\_\_

Home Phone: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening phone: \_\_\_\_\_

Name: \_\_\_\_\_ Spouse: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Spouse Occupation: \_\_\_\_\_

Place of Employ: \_\_\_\_\_ Spouse Place of Employ: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Spouse Work Phone: \_\_\_\_\_

Do you have Internet Access? Yes \_\_\_ No \_\_\_ E-Mail Address: \_\_\_\_\_

Do you have a regular Veterinarian? Yes \_\_\_ No \_\_\_ Dr. \_\_\_\_\_

Which animal hospital? \_\_\_\_\_

Has your pet been seen within the past month? \_\_\_\_\_ 6 months? \_\_\_\_\_ Year? \_\_\_\_\_

Is your pet on any medications at this time? \_\_\_\_\_

### How did you hear of our hospital?

Person/friend that we may thank? \_\_\_\_\_

Your regular Vet's answering service? \_\_\_\_\_

Our outside sign? \_\_\_\_\_

The Yellow Pages? \_\_\_\_\_

Website? \_\_\_\_\_

Other? \_\_\_\_\_

### Pet #1

Name: \_\_\_\_\_ Age/DOB: \_\_\_\_\_

Breed: \_\_\_\_\_ Color: \_\_\_\_\_

Sex: Male \_\_\_ Neutered \_\_\_ Female \_\_\_ Spayed \_\_\_

MEDICAL Vaccinations Date Given

HISTORY: \_\_\_\_\_

\_\_\_\_\_

Previous Illness or Surgeries \_\_\_\_\_

\_\_\_\_\_

### Pet #2

Name: \_\_\_\_\_ Age/DOB: \_\_\_\_\_

Breed: \_\_\_\_\_ Color: \_\_\_\_\_

Sex: Male \_\_\_ Neutered \_\_\_ Female \_\_\_ Spayed \_\_\_

MEDICAL Vaccinations Date Given

HISTORY: \_\_\_\_\_

\_\_\_\_\_

Previous Illness or Surgeries \_\_\_\_\_

\_\_\_\_\_

**I understand and agree that it is the policy of this Hospital to receive payment as services are rendered and that a deposit will be required upon admission to our Hospital for patient treatment.**

**I am the responsible owner of this pet and represent all other owners.**

Date \_\_\_\_\_ Signature of legal owner/responsible person (*You must be over 18 to sign this document*) \_\_\_\_\_

Method of Payment: \_\_\_CASH \_\_\_CHECK \_\_\_DEBIT \_\_\_VISA \_\_\_MC \_\_\_AMEX \_\_\_DISC

### Information required for check payment or hospitalization:

Your SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Co-Owner SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Your DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Co-Owner DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Driver Lic. #: \_\_\_\_\_

Co-Owner Driver Lic. #: \_\_\_\_\_