Averill Animal Hospital

(Please fill out completely)

Owner's Name(s): _____

Street Address:_____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Social Security #: _____ Driver's License #: _____

Email address:_____

Have you had pets before? ☐ Yes ☐ No Who referred you? _____

Preferred Method of Payment: ☐ Cash ☐ Check ☐ Visa ☐ MasterCard ☐ Discover ☐ Care Credit

Pet's Name: _____ Species: Canine or Feline or Other: _____

Breed: _____ Color: _____

Birthdate: _____ Sex: Male or Female ☐ Spayed ☐Neutered ☐Intact

Is your pet microchipped? ☐ No ☐ Yes Microchip number: _____

Dates of Last Vaccinations

Canine: DHLPP: _____ Corona: _____Rabies: _____ ☐ 1 year ☐ 3 year

Lyme: _____ Heartworm test: _____ Fecal Check: _____

Kennel Cough (Bordatella): _____

Type of Heartworm Preventative: ☐ Monthly What type? _____ ☐ None

Feline: FVRCP: _____ Chlamydia: _____ Leukemia: _____

FIP: _____ Rabies: _____ ☐ 1 year ☐ 3 year

Boarding and Hospital Policies

1. All pets entering the hospital must be current on vaccinations. If they are not, vaccinations will be given by our doctors. Bordatella (Kennel Cough) must have been given within the last six months.
2. All pets will be checked for external parasites and will be treated if necessary.
3. All pets boarding will be given a bath at the owner's expense before they are picked up.
4. Pick up time is by 2:00 p.m. All pets picked up after this time will be charged for an additional day.
5. In case of emergency, I give the doctors and staff of Averill Animal Hospital permission to treat my pet at the doctor's discretion.

I hereby authorize Averill Animal Hospital to examine, prescribe for, treat, or perform surgery upon the above described pet(s). I also consent to the administration of such anesthetics as are necessary. I have read and understand the above boarding and hospital policies. Furthermore, I agree to pay fees for services rendered at the time my pet is discharged from the hospital or when service is otherwise terminated.

Signature of Owner or Responsible Agent: _____ Date: _____

How old was your pet when you acquired it? _____

How many hours is your pet outside each day? _____

What is the best time to reach you at home? _____

Are there any prior illnesses or injuries we should know about? _____

_____

Is your pet on any medications or special diet? _____

_____

What healthcare or grooming products are you currently using on your pet? _____

_____

Are any of the following of concern to you about your pet's behavior?

□ Excessive barking □ Biting □ Shedding □ Straying from home □ Odor □ Housebreaking

□ Problems around children □ Itching □ Wetting or spraying □ Overly rambunctious

Which do you feel most applies to you? (Please mark the boxes with your preferences)

1. □ I feel that my pet is another member of our family.
   □ I feel that my pet is just a pet.
2. □ I want the best medical care available for my pet. Please recommend anything you feel is necessary for good health.
   □ I want good medical care for my pet, but there is a limit to what I am able to have done.
   □ I want you to perform only the services I request.
3. □ I want to learn as much as possible about my pet's health care. Please explain in detail what is needed.
   □ I would prefer you just summarize what has been done for my pet or what is needed.
   □ I want my pet healthy but I don't need to know what has been done.
4. □ I prefer to be present when my pet is examined and/or treated.
   □ I would rather not see my pet examined or treated.

Would you like for us to keep you informed about advances that lengthen or improve your pet's life?

□ Yes □ No