ELKRIDGE ANIMAL HOSPITAL

The original Elkridge Veterinarian - proudly serving Elkridge and surrounding communities since 2007

Client Information

Thank you for giving us the opportunity to care for your pet. Please help us meet your needs better by taking a moment to share important information we will need to meet the health care needs of your pet. All information is kept in strict confidence.

Owner's Name _____ Co-owner's Name _____
FIRST LAST FIRST LAST

Primary Phone _____ Primary Phone _____
PLEASE CHOOSE ONE PLEASE CHOOSE ONE

Secondary Phone _____ Secondary Phone _____
PLEASE CHOOSE ONE PLEASE CHOOSE ONE

Your mobile number will automatically be enrolled in our text notifications service specifically regarding any upcoming appointments. I understand that my normal carrier's standard text or data charges may apply.

Email _____ Email _____

Providing your email gives us permission to contact you regarding your pet, invoices, appointments, and future marketing. We will not share any of your personal information with any other companies or entities.

Address _____
HOUSE NUMBER & STREET NAME APT #

_____
CITY STATE ZIP CODE

How did you hear about our practice? ☐ Internet ☐ Mailing

☐ Hospital Signage ☐ Other _____

☐ Individual, someone we can thank? _____

Payment Policy

Please feel free to request an estimate for any services before they are rendered. All payments are due at time of service, as we do not have a billing system and cannot extend credit. We accept cash, checks, debit cards, American Express, Discover, MasterCard, Visa and CareCredit. A deposit may be required for hospitalized patients.

Signature_____ **Date**_____

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Patient Information

Owner's Name _____
FIRST LAST

Patient's Name _____

Species: ☐ **Dog** ☐ **Cat** **Breed:** _____

Color/ Markings: _____ **Date of Birth/ Age:** _____

Sex: ☐ **Male** ☐ **Female** **Altered:** (SPAYED/ NEUTERED) ☐ **Yes** ☐ **No**

Microchipped: ☐ Yes ☐ No Does your pet have pet insurance? ☐ Yes ☐ No

Does your pet have any previous medical conditions or on any current medications? ☐ Yes ☐ No

_____

Does your pet have any allergies to any medications or food? ☐ Yes ☐ No

_____

_____ I grant Elkridge Animal Hospital, its representatives and employees the right to photograph my pet and to copyright, use and publish such photographs with or without my pet's name for any lawful purpose in print and/or digitally (including Facebook/Instagram) for purposes such as publicity, illustration, advertising and web content.
INITIAL

Please provide the most recent vaccination records for your pets or provide us with the name of your previous vet so we can request a transfer of records on your behalf.

Name and location of previous veterinarian _____

My signature below authorizes Elkridge Animal Hospital to request the records from my previous vet if I have provided the necessary information.

Signature _____ Date _____