

WELCOME TO PARKSIDE

Client Information

Ms. Mrs. Mr. Dr.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone:() _____ Cell:() _____ DOB: _____

Employer: _____ Work:() _____

Spouse/Co-Owner: _____ Phone:() _____

Emergency Contact Name: _____ Phone:() _____

How did you hear about us (circle one)?

Internet Phone Book Sign/drive by Rescue group/Shelter Other: _____

Email address: _____

Is it ok to contact you via email or text message? _____ Which one do you prefer (circle)? Email Text

Do you give Parkside Veterinary Hospital permission to post any photos that we take of your pet? _____

Pet Information Dog Cat

Pet's Name: _____ Color: _____

Age: _____ Birthdate: _____ Breed: _____

Male Female Neutered/Spayed Yes No – If yes, at what age? _____

Do you need us to call your previous veterinarian to have records transferred? _____

If so, what is the name and phone number of the previous vet? _____

Any previous illnesses/surgeries? _____

AT YOUR REQUEST WE WILL GLADLY DISCUSS COST OF SERVICES AND/OR PREPARE A WRITTEN ESTIMATE FOR RECOMMENDED PROCEDURES. PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE PERFORMED. DEPOSITS ARE REQUIRED FOR PETS BEING ADMITTED.

I understand every effort will be made to achieve a successful outcome and to provide for all possible safety in hospital care and handling. I hereby authorize Parkside Veterinary Hospital to receive, prescribe, treat or perform surgery upon my pet listed above. I assume responsibility for all charges incurred in the care of the animal. I also understand that ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.

Signature _____ Date: _____