



WELCOME TO THE COASTAL CAT CLINIC!

Thank you for trusting us with your pet's health.
Please take a moment to tell us about you and your pet.



CLIENT INFORMATION

Owner's Name _____

Spouse/Co-Owner _____

Mailing Address _____

City _____ Zip _____

Street Address (if different from above) _____

Home Phone # _____

Primary Email Address _____

Owner Cell Phone # _____

Work Phone # _____

Employer _____

Co-Owner Cell Phone # _____

Work Phone # _____

Employer _____

Emergency Contact (other than you) _____

Emergency Contact Phone # _____

How did you hear of us?

Google Facebook Hospital Website Yelp Drive By

Other (please specify) _____

Referral - Who may we thank? _____

PATIENT INFORMATION

Pet's Name _____

Dog Cat Other _____

Male Neutered / Un-neutered (Please circle one)

Female Spayed / Un-spayed (Please circle one)

Breed _____

Color _____

Approx. date of birth _____

Name and type of any other animal(s) that you own

Past veterinarian(s) where past records may be requested?

Was your pet treated for any illness in the past year?

No Yes Please explain problem(s), medication details if known or provide records.

Is your pet currently on any medications?

No Yes Please list or provide records.

Does your pet have any drug sensitivities or reactions?

No Yes Please provide list or records.

PUBLIC HEALTH Please check the boxes that apply as they could influence course of treatment or preventative recommendations.

- Children in household
- Person in home is immunosuppressed (Chemotherapy, Transplant, HIV)
- Pregnancy in household (a fetus's immune system is not fully developed)
- Pet used for therapy (taken to nursing homes etc.) or service pet



FINANCIAL INFORMATION

I hereby authorize Coastal Cat Clinic and its veterinarians to examine, prescribe for, and treat the above described pet.

I release Coastal Cat Clinic and its veterinarians from any liability related to any such care. _____ Initial

I authorize Coastal Cat Clinic to use my pet's likeness for marketing purposes, including but not limited to use on their website or Facebook page. _____ Initial

I assume full responsibility for all charges incurred and I understand that a deposit may be required for hospitalization and/or treatment. I understand that ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED and agree to pay for services. _____ Initial

I understand that there is a minimum \$20.00 service charge for all returned checks. Any unpaid accounts more than 30 days past due will be sent to a collection agency. _____ Initial

Signature of Owner or Financially Responsible Party

(Must be 18 years or older) _____ Today's date _____

We accept: Cash & Check / Debit Card / AMEX & Discover / Visa & MasterCard / CareCredit / U.S. Credit System