

**Mountain Empire Small Animal Hospital**  
**CLIENT / PATIENT INFORMATION FORM**

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

**\*Required Information**

\*Client Name: \_\_\_\_\_ Social Security No. \_\_\_\_ - \_\_\_\_ - \_\_\_\_

\*Address: \_\_\_\_\_ \*Driver's License No. \_\_\_\_\_

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

\*Home Phone #: \_\_\_\_\_ \*Work Phone #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Co-Applicant: \_\_\_\_\_ Social Security No.: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Address: \_\_\_\_\_ Driver's License No.: \_\_\_\_\_

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

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Name of anyone else authorized to order treatment or obtain patient information (optional):

\_\_\_\_\_

Animal's Name: \_\_\_\_\_ Dog \_\_\_\_ Cat \_\_\_\_ Bird \_\_\_\_ Other \_\_\_\_

Breed: \_\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_ Neutered \_\_\_\_ Spayed \_\_\_\_

Age: \_\_\_\_\_ Birthdate: Month/Year \_\_\_\_ / \_\_\_\_ Color: \_\_\_\_\_

Last Distemper /Parvo: \_\_\_\_\_ Last Rabies: \_\_\_\_\_ Where Given: \_\_\_\_\_

Any known health problems or allergies: \_\_\_\_\_

Other Pets in Household:

Name:

Breed:

\_\_\_\_\_

\_\_\_\_\_

**Payment Is Due When Services Are Rendered**

**Method of Payment:** Cash \_\_\_\_ Check \_\_\_\_ MasterCard \_\_\_\_ Visa \_\_\_\_ Discover \_\_\_\_

\_\_\_\_\_

Applicant Signature

Co-Applicant Signature

**PHOTO IDENTIFICATION IS REQUIRED FOR ALL PAYMENTS EXCEPT CASH**