

South Arlington Animal Clinic

3315 South Collins St. Arlington, TX 76014 817-274-3328 www.arlingtonanimalclinic.com

CLIENT AND PATIENT INFORMATION SHEET

Pet Owner's Name _____ Spouse/Co-Owner _____

Address _____ City _____ State _____ Zip _____

Home# _____ Cell# _____ Spouse/CoOwner# _____

Work # _____, If necessary, may we call you at work? _____

E-mail address (we will send reminders for vaccinations) _____

PET INFORMATION

	Pet #1	Pet #2
Patient Name		
Species (Dog/Cat)		
Breed		
Sex : M / F	<input type="checkbox"/> M or <input type="checkbox"/> F	<input type="checkbox"/> M or <input type="checkbox"/> F
Neutered / Spayed ?	<input type="checkbox"/> Y or <input type="checkbox"/> N	<input type="checkbox"/> Y or <input type="checkbox"/> N
Birth Date		
Color		
Allergies to Medications		
Date of Last Rabies Vaccine		
Is your pet microchipped?	<input type="checkbox"/> Y or <input type="checkbox"/> N	<input type="checkbox"/> Y or <input type="checkbox"/> N
Name of Heartworm and/or Flea prevention?		

PAYMENT POLICY: FULL PAYMENT IS REQUIRED UPON RENDERING OF SERVICES.

Deposits are required on major medical/surgical/trauma cases and emergency work where the pet may need hospitalization. We accept Check, Cash, Visa, Mastercard, Discover, American Express and Care Credit. If paying by check please indicate License # _____

We do not carry open accounts and hope the above alternatives are convenient for you. I agree to pay any costs and charges necessary for the collection of any amount not paid when due. To prevent the spread of infectious diseases and parasites, hospitalized or boarding animals must be current on vaccinations and be free of internal and external parasites. I authorize South Arlington Animal Clinic to provide vaccines and parasite control when needed.

SIGNATURE OF OWNER OR AUTHORIZED REPRESENTATIVE: _____