

Welcome to Rolling Hills Pet Clinic

Last Name _____ First Name _____

Address _____

City _____ Zip _____ Home Phone _____

Work Phone _____ Cell Phone _____

Spouse _____ Referred by _____

Drivers License Number _____

Employer _____

**Active Military _____ **Senior (65 or older) _____

PET INFORMATION

Name	Age or D.O.B.	Cat	Dog	Color	Breed	Sex		Altered
						F	M	
						F	M	Y / N
						F	M	Y / N
						F	M	Y / N
						F	M	Y / N
						F	M	Y / N
						F	M	Y / N

Client Authorization: I hereby authorize the veterinarian to examine, prescribe for or treat pet(s) under my care. I understand this hospital does not offer 24 hour monitoring and I assume all responsibility for all charges incurred for the care of my pet(s). I further understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment.

Client Signature _____ Date _____