Animal Health Services

INC. PS–Longview

Complete Animal Care

Dr. N.D. Kuehlwein
Dr. E.T. Lillevold

Welcome to our Hospital. So that we may become better acquainted, please complete the following:

Name (Last, First, Middle Initial) ______________________ S.S. # ______________

Spouse/Friend ______________________ S.S. # ______________

Street ______________ City ______________ State ________ Zip Code ________

Mailing Address ______________ City ______________ State ________ Zip Code ________

Telephone (Home) # ______________________ Email ______________

Employer (Name) ______________________ (Work #) ______________

PATIENT ______________ SEX: M F Neutered Yes No Age ________

Breed ________ *Color* ________ *Wt.* ________ *Last worm check* ________

Has your pet ever had vaccinations? No ❑ Yes ❑ If yes, when? Leukemia blood test negative? No ❑ Yes ❑

Dog ❑ *Parvo/Distemper* ________ (Date) *Corona* ________ (Date) *Rabies* ________ (Date) *Kennel cough* ________ (Date) *Lymes* ________ (Date)

Cat ❑ *Distemper* ________ (Date) *Feline Leukemia* ________ (Date) *Rabies* ________ (Date) *Chlamydia* ________ (Date) *FIP* ________ (Date)

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Why are you bringing your pet in? ______________________

How did you choose our hospital? ❑ Personal Recommendations ❑ Yellow Pages ❑ Radio ❑ Newspaper

❑ Other ______________________

WHOM MAY WE THANK FOR REFERRING YOU TO US? ______________________
(Please print person's name and address)

HAVE YOU BEEN TO A VETERINARIAN BEFORE? ❑ Yes ❑ No ______________________
(Doctor or Clinic Name)

I VERIFY TO BE THE OWNER OR AGENT OF THIS PET AND I GRANT PERMISSION TO ANIMAL HEALTH SERVICES TO VACCINATE, TREAT OR PERFORM ANY RECOMMENDED/REQUESTED OR EMERGENCY MEDICAL CARE TO MY PET.

METHOD OF PAYMENT. ALL CHARGES ARE DUE AND PAYABLE UPON PATIENT'S RELEASE.

❑ Cash ❑ Check ❑ Visa ❑ MasterCard ❑ Discover ❑ Carecredit ❑ American Express

IT IS OUR POLICY TO PROVIDE YOU WITH AN ESTIMATE OF CHARGES FOR ANY CASE WHERE IN-HOSPITAL TREATMENT, SURGERY, OR HOSPITALIZATION WILL BE PROVIDED. A DEPOSIT PRIOR TO TREATMENT WILL BE REQUIRED DEPENDING UPON THE AMOUNT OF THE ESTIMATE. ALL DISCOUNTED SERVICES, INCLUDING SPAYS, NEUTERS, ETC., MUST BE PAID WHEN PET IS CHECKED IN. THE BALANCE AFTER DEPOSIT AND ALL OTHER SERVICES ARE DUE AND PAYABLE ON PET'S RELEASE. IN THE EVENT LEGAL ACTION SHOULD BECOME NECESSARY TO COLLECT ANY UNPAID BALANCE DUE FOR VETERINARY SERVICES RENDERED TO MY PETS, I/WE AGREE TO PAY REASONABLE ATTORNEY FEES OR OTHER SUCH COSTS AS THE COURT DETERMINES PROPER. I AGREE THAT THE VENUE FOR ANY LEGAL ACTION SHALL BE IN COWLITZ COUNTY.

Signature ______________________ Date ______________