

# HAZELWOOD PET CARE

**Welcome! Please fill out this form completely so that we can provide the best care possible.**

## Client Information:

Owner Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Email: \_\_\_\_\_ Preferred contact: Call\_\_ Text\_\_ Email\_\_  
Spouse/Partner Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Preferred contact: Call\_\_ Text\_\_ Email\_\_  
How did you find us: Facebook\_\_ Instagram\_\_ Website\_\_ Referred by: \_\_\_\_\_  
Previous veterinarian to obtain records: \_\_\_\_\_  
Do you have pet insurance? If so, which company? \_\_\_\_\_

## Pet Information: (please use the back for additional pets)

Pet Name: \_\_\_\_\_ Birthday (best guess): \_\_\_\_\_  
Breed: \_\_\_\_\_ Sex: M\_\_ F\_\_ Spayed/Neutered: Yes\_\_ No\_\_  
Color/markings: \_\_\_\_\_ Has microchip: Yes\_\_ No\_\_  
Date of last vaccines: \_\_\_\_\_ History of vaccine reaction/allergy: Yes\_\_ No\_\_  
Current medication(s): \_\_\_\_\_  
Pet Name: \_\_\_\_\_ Birthday (best guess): \_\_\_\_\_  
Breed: \_\_\_\_\_ Sex: M\_\_ F\_\_ Spayed/Neutered: Yes\_\_ No\_\_  
Color/markings: \_\_\_\_\_ Has microchip: Yes\_\_ No\_\_  
Date of last vaccines: \_\_\_\_\_ History of vaccine reaction/allergy: Yes\_\_ No\_\_  
Current medication(s): \_\_\_\_\_

**I authorize Hazelwood Pet Care to take photos and/or videos of my pet(s) and their experience for use on Facebook, Instagram, the business website, and/or any other forms of social media for advertising and marketing purposes: Yes\_\_ No\_\_**

I hereby authorize the veterinarians of Hazelwood Pet Care and their employees to examine, prescribe for, and/or treat my pet(s). I assume responsibility for all charges incurred during their care. All fees are due when services are rendered. When extensive care is indicated, a deposit may be required. An estimate can be provided upon request. Should I fail to pay for any service rendered by Hazelwood Pet Care, I will be responsible for all service charges and collection charges incurred by the practice. There is a \$35 NSF fee on checks returned for non-payment.

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

\*We kindly ask for 24-hour notice for all appointment cancellations and reserve the right to charge for missed appointments.