

Tigertown Veterinary Hospital

Thank you for giving Tigertown Veterinary Hospital the opportunity to care for your pet(s).

So that we may become better acquainted, please complete the following:

Name: _____ Spouse/Co-owner Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Primary Phone: _____ Secondary Phone: _____

Place of employment: _____ Work Phone: _____

Spouse/Co-owner Place of Employment: _____ Work Phone: _____

Social Security # _____ DL # _____ Email: _____

Are you on facebook? - May we send you a friend request?: _____

Please let us know how you heard about our clinic _____



Patient Information

1

2

3

___ Dog ___ Cat ___ Other

___ Dog ___ Cat ___ Other

___ Dog ___ Cat ___ Other

Name: _____

Name: _____

Name: _____

DOB/Age: _____

DOB/Age: _____

DOB/Age: _____

Color: _____

Color: _____

Color: _____

Breed: _____

Breed: _____

Breed: _____

___ Male ___ Female

___ Male ___ Female

___ Male ___ Female

___ Neutered ___ Spayed

___ Neutered ___ Spayed

___ Neutered ___ Spayed

**Any additional information:

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet (s). I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid at the time services are rendered. If for any reason your account is turned over for collections, a collection fee will be added to the amount due. We accept cash, check, VISA, Discover, American Express and Care Credit.

All medical procedures, including vaccinations, have some inherent risk. If you have any questions or concerns about our procedures and/or vaccinations, please discuss them with the doctor.

Signature of Owner

Date