Please print this form, fill it out, and bring it with you for your appointment

SHAKER VETERINARY HOSPITAL, PC
223 Maxwell Road
Latham, New York 12110
(518) 458-9669

CLIENT INFORMATION

Office Use Only

Date: ___________

SVH: ___________

Owner's Last Name:_________________________________ First Name: ______________________ MI: _______

Phone:____________________ Business Phone: ____________________ E-Mail: ______________________

Address:________________________________ City: ______________________ State: ______ Zip: ________

Occupation: ______________________________ Employer Name: ____________________________________

Employer's Address:___________________________ City: ___________________ State: ______ Zip: ________

Spouse Name: ___________________ Employer: ________________________ Business Phone: _____________

Dog	Cat	Pet's Name	Breed	Color	Date of Birth or Age	Sex	Altered	Dog			Cat	
								Rabies	DHLP-P	Bordatella	Rabies	FDV-RTC

OTHER INFORMATION

In case of emergency, if we cannot reach you, whom should we call?

Name: _______________________________ Phone: ______________________ Relationship: ______________

Referred/Recommended by: _________________________ Previous Veterinarian: __________________________

Is your pet microchipped? ___ No ___ Yes Usual Diet (Include Brand Names) ___________________________

How long have you had your pet? ___________________ How did you acquire your Pet? _____________________

Is your pet allergic to Drugs, Food, Fleas? ___ No ___ Yes Specify_____________________________________

List any major disease, illness, or injury your pet has had: ____

Currently on medication? ___ No ___ Yes Specify ____

PROFESSIONAL FEES ARE TO BE PAID AT TIME SERVICES ARE RENDERED

I certify that I am the owner of the animal(s) listed above. I am at least eighteen (18) years of age and I assume total financial responsibility for the costs of services rendered by Shaker Veterinary Hospital, PC.
Signature of Owner:____

I acknowledge that I am not the owner of the animal(s) listed above. I have been authorized by the owner to act on their behalf. I certify that I am at least eighteen (18) years of age and I assume total financial responsibility for the cost of services rendered by Shaker Veterinary Hospital, PC as well as responsibility for the decisions regarding care and treatment of the animal(s) described herein.
Signature of Agent:____