PARK CENTRE ANIMAL HOSPITAL
2501 Central Avenue
Alameda, CA 94501
(510) 521-1700

Thank you for giving us the opportunity to care for your pets. So that we may become better acquainted, please complete the following:

Client Information

First & Last Name _____ Co-Owner's Name/Relationship _____

Address _____ Co-Owner Cell # _____

City, State & Zip _____ Co-Owner Work # _____

Home # _____ Cell # _____

Work # _____ Email: _____

How did you choose our clinic?

Drove by [ ]
Referral [ ] Whom may we thank? _____
Yellow Pages [ ]
Internet [ ] Where? _____
Newspaper [ ]

Previous Veterinarian _____

May we contact them in order to get a copy of your pet's medical records? _____

Pet Information

Pet #1 Dog [ ] Cat [ ] Other [ ]	Pet #2 Dog [ ] Cat [ ] Other [ ]
Pet's Name:	Pet's Name:
Approx Date of Birth or Age:	Approx Date of Birth or Age:
Breed: Male [ ] Female [ ]	Breed: Male [ ] Female [ ]
Color:	Color:
Reason for Visit Today:	Reason for Visit Today:
Has your pet been spayed/neutered? Yes [ ] No [ ]	Has your pet been spayed/neutered? Yes [ ] No [ ]

Is your pet currently taking medications? _____ What are you feeding your pet? _____

Is your pet sensitive to touch in any part of the body? _____

Has your pet ever had a negative veterinary experience? _____

Does your pet have any known allergies, previous major illnesses or surgeries, or reaction to vaccinations?

_____

Is there anything else you would like us to know? _____

_____

For Cats: Does your pet go outside or have contact with other cats? _____

ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED

I assume all responsibility for all charges incurred in the treatment of my pet(s). I also understand that these charges will be paid at the time of release and that a deposit may be required for any treatment for which the pet is left in the hospital. I further assume responsibility for any collection fees or attorney's fees necessary to collect the full amount due.

_____ _____

Signature of Owner or Responsible Party Date