

**Welcome To Care Animal Center**  
**3454 West Main Street - - Dothan, Alabama 36305**

We would like to become the caretaker of your pets.  
If you have never visited Care Animal Center, please complete  
the following Client Information pages (2 pages) and telephone us  
for an appointment time.

**Client Information**

The Doctor's and Staff of Care Animal Center welcome you. Thank you for giving us the opportunity to care for your pet(s). Please help us better meet your needs by taking a few moments to fill out and sign the following client and patient information sheets.

Owner Name \_\_\_\_\_ Spouse/Other \_\_\_\_\_

Owner SSN # \_\_\_\_\_ Spouse/Other SSN # \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Email Address \_\_\_\_\_

Children's Name \_\_\_\_\_

Employer's Name & Address \_\_\_\_\_

Spouse/Other Employer Name & Address \_\_\_\_\_

Spouse/Other Cell Phone # \_\_\_\_\_ Spouse/Other work phone # \_\_\_\_\_

Did someone refer you to our hospital? If so, whom may we thank? \_\_\_\_\_

We will gladly prepare a written estimate if you so desire. Please ask a receptionist or doctor. Professional fees are due at time services are rendered. If you wish to pay by check or credit card, please complete the following:

Owners Driver's License and State \_\_\_\_\_

Spouse/Other Driver's License and State \_\_\_\_\_

Preferred Method of Payment:      ( ) Cash      ( ) Check      ( ) Credit Card

**DUE TO STATE LAW, ALL DOGS & CATS MUST BE CURRENT ON RABIES VACCINATION.** To help prevent the spread of infectious disease, hospitalized and boarded animals must be current on required vaccinations. Proof of vaccination must be presented at time of check-in or vaccinations will be administered.

I understand every effort will be made to achieve a successful outcome and to provide for all possible safety in hospital care and handling. I hereby authorize this hospital to receive, prescribe for, treat or perform surgery upon the pet(s) listed on this form and additional pets I present. Furthermore, I agree to pay fees for services rendered at the time the pet is discharged from the hospital or as agreed prior to treatment. I understand that a reasonable service fee will be assessed for each not-sufficient fund check and/or certified letter that must be sent. I understand that veterinary service is provided during nighttime hours as necessary in the judgment of the veterinarian on call. Continuous presence of qualified personnel may or may not be provided. If I neglect to pick up my pet within one week of the discharge date and fail to notify this hospital within that time period, steps as described by law will be undertaken to consider my pet(s) abandoned.

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

## Patient Information

Name of previous Veterinarian or Veterinary Clinic \_\_\_\_\_

Please provide as much information as possible for each pet. Please note the dates the following vaccines or test were administered.

Pet's Name \_\_\_\_\_

Species (Dog, Cat, Bird, etc.) \_\_\_\_\_

Breed \_\_\_\_\_

Description (Color and Markings) \_\_\_\_\_

Age or Date of Birth (Approximate) \_\_\_\_\_

Sex \_\_\_\_\_ Male ( ) Female ( )

Neutered or Spayed? \_\_\_\_\_ Yes ( ) No ( )

Diet (Name of Your Pet's Food) \_\_\_\_\_

Medications, Heartworm Preventive \_\_\_\_\_

Flea Preventive \_\_\_\_\_

**DOGS** Rabies \_\_\_\_\_ Approximate date: \_\_\_\_\_

DA2PP (Distemper/Pravo) \_\_\_\_\_ Approximate date: \_\_\_\_\_

Bordetella (Kennel Cough) \_\_\_\_\_ Approximate date: \_\_\_\_\_

Rattlesnake Vaccination \_\_\_\_\_ Approximate date: \_\_\_\_\_

Heartworm Test \_\_\_\_\_ Approximate date: \_\_\_\_\_

Fecal Exam (test for worms) \_\_\_\_\_ Approximate date: \_\_\_\_\_

**CATS** Rabies \_\_\_\_\_ Approximate date: \_\_\_\_\_

FVRCP (Infectious Disease) \_\_\_\_\_ Approximate date: \_\_\_\_\_

FELV (Feline Leukemia) \_\_\_\_\_ Approximate date: \_\_\_\_\_

FIP (Feline Infectious Peritonitis) \_\_\_\_\_ Approximate date: \_\_\_\_\_

FELV / FIV Test \_\_\_\_\_ Approximate date: \_\_\_\_\_

Fecal Exam (test for worms) \_\_\_\_\_ Approximate date: \_\_\_\_\_

Other Vaccines – Please specify \_\_\_\_\_

Medical History \_\_\_\_\_