



Deerwood Animal Hospital
1709 Nottingham Way
Hamilton, NJ 08619
(609) 588-8075
info@deerwoodanimalhospital.com

CLIENT INFORMATION

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Cell Phone: _____ Home Phone: _____

E-mail Address: _____

How did you learn about our practice? _____

PET INFORMATION

Pet's Name: _____

Species (Please Check One):

Canine _____ Feline _____ Rabbit _____ Color _____

Sex (Please Check One):

Male _____ Female _____ Neutered/Spayed (Yes) _____ Neutered/Spayed (No) _____

Breed: _____

Birthday (MM/DD/YYYY): _____ Age: _____

List Your Pet's Current Medication(s): _____

AUTHORIZATION

I, the undersigned owner or authorized agent of the admitted pet, authorize the veterinarians and staff of Deerwood Animal Hospital to administer treatment and perform any necessary therapeutic and/or diagnostic procedures. I understand that no guarantees are made regarding the outcome of treatment. I certify that I am at least 18 years of age, legally responsible for this pet's care, and agree to assume full financial responsibility for all charges incurred. **FULL PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.** If full payment is not made as required, I consent to Deerwood Animal Hospital obtaining my credit information from an authorized agency for collection purposes. I understand that all personal and financial information will be handled in compliance with applicable privacy laws.

SIGNATURE: _____ **DATE (MM/DD/YYYY):** _____