# Holcomb Bridge Animal Hospital
# Patient and Client Information Sheet

**1575 Holcomb Bridge Road, Roswell, GA 30076 (770) 998-8865**

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

## Client Information

Name: First_____ Middle_____ Last_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Email_____

Employer_____ Occupation_____ Work Phone_____

If Necessary, may we contact you at work? ☐ yes ☐ no

How did you become aware of our clinic? _____

Alternate Emergency Contact:_____ Home Phone_____

Work Phone:_____

## Pet Information

Name_____ Species_____ Breed_____

Birth Date:____/____/____ Sex_____ Spayed/Neutered?_____ Color_____

Microchip Number_____ Tattoos or other identifying markings?_____

Previous Veterinary Clinic_____ Phone Number_____

Previous Illness/Injuries/Surgeries_____

Current Medications or Special Diets_____

Known Allergies to: ☐ Drugs:_____ ☐ Food:_____

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☐ Vaccines:_____ ☐ Other:_____

Is your pet on heartworm prevention?_____ What king?_____

How long have you owned your pet?_____ Origin of Pet:_____

What kinds of shampoos or flea control products do you use?_____

Reason for today's visit?_____

## Payment Information

## PLEASE READ CAREFULLY AND SIGN BELOW

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, and / perform surgery upon the pet(s) that I present. We will gladly prepare a written estimate at any time that you may so desire, just ask a receptionist, technician, or doctor. Professional fees are due at the time services are rendered. Furthermore, I agree to pay fees for services rendered at the time the pet is discharged from the hospital or the service is terminated. I agree to pay any and all reasonable costs of collection in the event that collection efforts become necessary. I understand that a service fee of $25.00 will be assessed for each non- sufficient fund check and / or certified letter that must be sent.

To prevent the spread of infectious diseases, all hospitalized and boarded patients must be current on all vaccines and free from internal and external parasites. The signature below authorizes this level of preventative care and the appropriate charges will be assessed in the discharge invoice.

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Please indicate your choice of payment:

☐ Cash ☐ Check ☐ Debit Card ☐ Credit Card

Signature of Owner of Authorized Agent:_____ Date_____

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*Please write any additional information on the back of this form.*