

ANIMAL CARE HOSPITAL OF REYNOLDSBURG, INC.
7775 E. MAIN STREET REYNOLDSBURG, OHIO 43068
JOEL E. MELIN, DVM MARY KAY SCHWAB, DVM
614-864-0465
www.animalcarehospitalofreynoldsburg.com

Thank you for giving our hospital the opportunity to care for your pet. We hope you are pleased with our services, staff, and facilities. Please let us know if there is anything we can do to improve your experience with us.

To help us help you and your pet, please complete the following (*front and back*)

Today's Date: _____
Owner: _____ Significant Other _____
Street Address: _____
City: _____ County _____ State: _____ Zip: _____
Home Phone No.: _____ Cell Phone No.: _____
Owner's place of Employment: _____ Phone No. _____
Sig. Other's Place of Employment: _____ Phone No. _____
If necessary, may we call you at work: YES NO
Email Address _____

In case of an emergency, the nearest relative or friend who does not live with you:

Name: _____ Address: _____
Relationship: _____ Phone No.: _____

How did you become aware of our hospital?

Yellow Pages _____ Hospital Sign _____ Website _____ Other _____

Personal Recommendation – Who may we thank? _____

PAYMENT POLICY

PROFESSIONAL FEES ARE TO BE PAID AT THE TIME SERVICES ARE RENDERED

Please indicate your choice of payment method: CASH CHECK MC / VISA / DISCOVER

WE DO NOT CARRY OPEN ACCOUNTS AND HOPE THE ABOVE ALTERNATIVES ARE CONVENIENT FOR YOU.

I agree to pay any costs and charges necessary for the collection of any account not paid when due.

Signature _____ Date _____

Continued on back.....

PATIENT INFORMATION

	PET #1	PET #2	PET #3
NAME			
BREED			
DATE OF BIRTH			
LENGTH OF OWNERSHIP			
COLOR			
SEX			
NEUTERED/SPAYED?			
LAST ANNUAL VACCINE			
LAST RABIES VACCINE			
LAST HEARTWORM CHECK (DOG)			
LAST HEARTWORM PILL (DOG)			
TESTED FOR LEUKEMIA? (CAT)			
USUAL DIET			
USUAL TREATS			
ALLERGIES (FLEAS, FOOD, DRUGS)?			
CURRENTLY ON MEDICATION?			
IF SO, WHAT KIND?			

Has your pet(s) had any health problems, surgeries, or injuries that we should know about?

TO BETTER UNDERSTAND YOUR VETERINARY NEEDS WE WOULD APPRECIATE KNOWING THE FOLLOWING:

1. Would you like to be present during the exam of your pet? YES_____ NO_____

2. How much time do you spend or anticipate spending with your pet during the average day?
 1 to 2 hours _____ 3 to 7 hours _____ 8 or more hours _____

3. Do you consider your pet:
 A member of the family _____ A working pet _____ An outside pet _____ An indoor pet _____

4. Where does (or will) your pet sleep?
 Outdoors _____ Crate/Carrier _____ Basement _____ Pet Bed _____ Beside your bed _____ In your bed _____

5. Is your pet allowed to (or will be allowed to):
 Sit on the furniture _____ Sit on people _____ Jump on people _____ Lick your face _____
 Eat out of your dish _____ Do whatever they want _____

6. Has your pet had professional training? YES_____ NO_____