Animal Medical Hospital of Centereach
2425 Middle Country Road
Centereach, NY, 11720
631-585-5353

INFORMATION SHEET
PLEASE PRINT AND COMPLETE

DATE _____

Have you been here before? _____

OWNER'S LAST NAME: _____ **FIRST NAME**: _____

SPOUSE'S FIRST/LAST NAME: _____

STREET ADDRESS: _____

CITY, STATE: _____ **ZIP CODE**: _____

HOME PHONE: _____ **CELL PHONE**: _____

WORK PHONE:_____ SPOUSE'S CELL PHONE: _____

*DRIVERS LICENSE NUMBER AND STATE ISSUED (**IF PAYING BY CHECK**)* _____

How did you hear about us? (CIRCLE ONE) Friend? Newspaper? Phonebook? Other _____

E-Mail Address for future correspondence (reminders, events, etc.) _____

EMERGENCY CONTACT: _____ *EMERGENCY CONTACT #:* _____

PET'S NAME: _____ **BREED**: _____

MEDICAL ALERTS: (EX. ALLERGIES, BITER, ETC.) _____

SPECIES: DOG CAT FERRET BIRD RABBIT REPTILE OTHER: _____

SEX: MALE FEMALE UNKNOWN **NEUTERED/ SPAYED**: YES NO UNKNOWN

COLOR: _____ **AGE:**_____ **D.O.B.:**_____

APPROX. WEIGHT:_____ **DR. PREFERENCE:** _____

LAST VISIT TO THE VETERINARIAN WAS _____

MY PET WAS SEEN BY DR._____ AT: _____

OTHER PETS: _____

FEE: I/WE UNDERSTAND THAT I/WE CAN REQUEST A WRITTEN ESTIMATE IF I/WE NEED. I/WE UNDERSTAND THAT A FINAL FEE WILL BE BASED ON ACTUAL SERVICES RENDERED. I/WE AGREE TO PAY THE FULL AMOUNT DUE AT TIME SERVICES ARE RENDERED OR WHEN THE ANIMAL(S) IS/ARE RELEASED FROM THE HOSPITAL, INCLUDING ANY BOARDING FEES. SHOULD THE HOSPITAL HAVE TO INSTITUTE COLLECTION PROCEEDINGS TO RECOVER ANY AMOUNT OWED BY ME/US, I/WE AGREE TO PAY ALL COSTS OF SUCH COLLECTION PROCEEDINGS. INCLUDING ANY LEGAL FEES INCURRED.

SIGNATURE OF OWNER OR AUTHORIZED AGENT:

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