

Client Information Form



Owner Name _____ Co-Owner _____

Mailing Address _____ City _____ State _____ Zip _____

Street Address (if different) _____

Home Phone _____ Cell _____ Work _____

Co-owner Cell _____ Work _____

Other persons authorized to make medical/financial decisions for your pets:

Name _____ Primary phone _____

Name _____ Primary phone _____

E-mail (for reminders, sending medical records, certificates, newsletters only - we do not give out any of your information) _____

Payment Method (circle one please) cash check visa mastercard

If paying by check, SS# _____ and driver's license _____

Previous Veterinarian/Hospital name _____ Phone # _____

How did you hear about us? (check all that apply)

___ Drive by ___ Andover Animal Hospital web site ___ Share the Care card referral

___ Other internet source (specify) _____

___ Local event (specify) _____ other ad (specify) _____

___ Referral (whom may we thank?) _____

I understand that payment is due in full at the time of service. There is no billing. I assume financial responsibility for all charges incurred for services rendered for my pets. I am over 18 years of age.

Signature of owner/agent _____ date _____

I give Andover Animal Hospital permission to post my pet's picture, story and general medical information on social media (for example, "Fluffy is diabetic and has been on insulin for 4 months, and is doing great)

Signature of owner/agent _____ date _____

Print name _____

Would you like to be added to our quarterly newsletter mailing list? _____ yes _____ no