



5156 GENESEE STREET BOWMANVILLE, NEW YORK 14026 PH 716.681.3033 FAX 716.681.3170 www.lancastersmallanimalhospital.com

Thank you for giving us the opportunity to care for your pet(s). So that we may become better acquainted, please complete the following:

CLIENT INFORMATION

Date _____

Name _____ Spouse's Name _____

Address _____ City _____ State _____ Zipcode _____

Phone _____ Work Phone _____ Spouse's Work Phone _____

Place of Employment _____ Best Time to Reach You _____

All Fees Are Due At The Time Services Are Rendered

I understand that I assume financial responsibility for all services rendered. In case of non-payment a finance charge will be added and I will be responsible for attorney and collection fees.

Please indicate choice of payment. Cash/Check Visa MasterCard Discover

How did you become aware of our clinic? Drove by Yellow Pages Previous Client

Personal Recommendation (Whom may we thank?) _____

Signature _____

	PET #1	PET #2	PET #3
NAME			
BREED			
DATE OF BIRTH			
COLOR			
SEX: SPAYED OR NEUTERED?			
YOUR DOG'S VACCINATION HISTORY:			
RABIES			
DISTEMPER PARVO			
CORONA BORDATELLA			
FECAL (STOOL SAMPLE)			
HEARTWORM TEST/PREVENTION?			
YOUR CAT'S VACCINATION HISTORY:			
RABIES			
DISTEMPER			
LEUKEMIA TEST			
LEUKEMIA VACCINE			
FECAL (STOOL SAMPLE)			

Our pet(s) is: Member of our family Child's pet Backyard pet

Any previous serious illnesses or surgeries? _____

Any allergies to vaccinations or medications? _____

Is your pet on any special diets or medications? _____

Would you like to be present during treatment to your pet? Yes No

Do you authorize us to call _____ at _____ Yes No for records?

If you have more than 3 pets, the receptionist will provide additional forms.