# Channel Islands Veterinary Hospital

## Patient/Client Information Sheet

Today's Date _____

THANK YOU FOR GIVING US THE OPPORTUNITY TO CARE FOR YOUR PET . PLEASE HELP US BETTER MEET YOUR NEEDS BY TAKING A MOMENT TO COMPLETE **BOTH** SIDES OF THIS INFORMATION SHEET.

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_____ _____ _____ _____

*(Owner's Last Name)* *(Owner's First Name)* *(Primary Contact Phone #)* *(Alternate Phone #)*

_____ _____ _____ _____

*(Co-owner's Last Name)* *(Co-owner's First Name)* *(Primary Contact Phone #)* *(Alternate Phone #)*

_____ _____ _____

*(Street Address)* *(City/State)* *(Zip Code)*

_____ _____ _____

*(Email Address)* *(Owners Date of Birth for controlled drug dispensing)* *(Driver's License #)*

_____ _____ _____

*(Alternate Emergency Contact)* *(Relationship)* *(Alternate Contact Phone #)*

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_____ _____ _____ _____

*(Pet's Name)* *(Breed)* *(Color)* *(Date of Birth)*

**SEX**
- ☐ Male
- ☐ Male Neutered
- ☐ Female
- ☐ Female spayed

Last physical exam: _____ *(Date)*

Last fecal parasite assay: _____ *(Date)*

Does your pet have a microchip? ☐ No ☐ Yes Microchip # _____ ☐ I don't know ☐ Please scan for number

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**PHOTO RELEASE**

I authorize Channel Islands Veterinary Hospital, it's representatives and employee, the right to take photographs of me and/or my pets to copyright, use and publish the same in print and/or electronically such as Facebook and Instagram.

I agree that Channel Islands Veterinary Hospital may use such photographs of me and/or my pets with or without my name and for lawful purpose, including, for example, such purpose as publicity, illustration, advertising, and web content.

_____

*(Signature)*

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HOW DID YOU BECOME AWARE OF OUR HOSPITAL?

☐ INDIVIDUAL-WHOM MAY WE THANK ? _____

| | | |
|---|---|---|
| ☐ PHONE BOOK | ☐ HOSPITAL SIGN | ☐ VENTURA COUNTY ANIMAL SERVICES |
| ☐ DIRECT MAIL | ☐ WEBSITE | ☐ ACORN |
| ☐ YELP | ☐ FACEBOOK | ☐ Other _____ |
| ☐ GOOGLE | ☐ LAS POSAS VETERINARY MEDICAL CENTER (SISTER HOSPITAL) | |

**PREVIOUS MAJOR MEDICAL HISTORY:** _____

**ALLERGIES:** _____

**CURRENT MEDICATIONS:** _____

**PREVIOUS VETERINARIAN:** _____
*(Name)* *(Hospital/Clinic)*

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## PET LIFESTYLE SURVEY

(Please mark all that apply)

**HOW LONG HAVE YOU OWNED YOUR PET?** _____

**MONTHLY FLEA CONTROL USED:** ☐ Simparica® ☐ Nexgard® ☐ Frontline® ☐ Other_____

**MONTHLY HEARTWORM PREVENTION USED:** ☐ Heartgard® ☐ Trifexis® ☐ Other_____

**WHEN I TRAVEL, MY PET:** ☐ Goes with me ☐ Boards at veterinary hospital ☐ Boards in kennel ☐ Is taken care of by neighbor/family

**MY PET EATS :** Brand name:_____ ☐ Dry food ☐ Wet food

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**MY OTHER PETS ARE:**

| ***NAMES*** | ***BREED*** | ***DOB / AGE*** |
|---|---|---|
| 1.) _____ | Canine / Feline _____ | _____ |
| 2.) _____ | Canine / Feline _____ | _____ |
| 3.) _____ | Canine / Feline _____ | _____ |

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## EMERGENCY CONTACT

In case of an emergency and I am not present or able to be contacted, I authorize treatment for
☐ patient named above ☐ and/or any other pets I own.
I understand that I will be fully reposnsible for any charges incurred.

Authorization given : ☐ Yes ☐ No _____ _____
*(Signature)* *(Date)*

**NOTE: IF MARKED NO OR LEFT BLANK, WE CANNOT RENDER ANY MEDICAL ATTENTION UNTIL YOU ARE CONTACTED AND AUTHORIZE US TO DO SO.**

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

We do not carry open accounts but offer the following methods of payment:
cash, debit cards, Visa, MasterCard, Discover, American Express and CareCredit.

I understand that professional fees are to be paid at the time rendered.
I authorize treatment for the patient named above and accept responsibility for charges incurred.

_____ _____ _____
*(Signature)* *(Printed Name)* *(Date)*

_____ _____ _____
*(Agent's Signature)* *(Printed Name)* *(Date)*