Randall Orchard Crossing Animal Hospital
1045 Orchard Road, North Aurora, IL 60542
Phone: (630) 723-6369 Fax: (630) 618-4824

CLIENT INFORMATION

THANK YOU FOR GIVING US THE OPPORTUNITY TO CARE FOR YOUR PET. Please fill out the following information for our files. All information is kept in strict confidence.

Thank You!

Owner's Name: _____
LAST FIRST SPOUSE/OTHER

Address: _____
CITY STATE ZIP

Email: _____

Primary Phone: (_____) _____ Phone Type (Circle one): Cell Phone Home Phone Work Phone Spouse/Relative
Alternate Phone: (_____) _____ Phone Type (Circle one): Cell Phone Home Phone Work Phone Spouse/Relative

Kane, DuPage or other: _____ Drivers License Number: _____ Date of Birth: _____

Please fill out for all your pets	**#1**	**#2**	**#3**
Pet's Name			
Species (Cat or Dog)			
Breed			
Description (Color/Markings)			
Age/Date of Birth			
Sex			
Spayed/Neutered			
Microchip Number			
MEDICAL HISTORY:			
Prior Illness or Surgery			
Known Allergies			
Date of Last Vaccines			
Diet			
Current Medications			
Aggression/Behavioral Issues			

If you do NOT have records for your pet(s), please list other clinic(s) they have been to so we can contact them.

_____
_____
_____

HOW DID YOU HEAR ABOUT OUR PRACTICE?

☐ Individual, someone we may thank? _____

☐ Yellow Pages ☐ Hospital Sign ☐ Mailing ☐ Other _____

Do you qualify for our **Senior Citizen Discount**? (Age 65 or older) Yes ☐ No ☐

Do you qualify for our **Military Discount?** Yes ☐ No ☐

May we use your **pet's picture** on our **social media/hospital website**? Yes ☐ No ☐

PAYMENT POLICY

All payments are due at the time **services** are **rendered**; we **DO NOT** invoice or have lines of credit. We accept cash, all major credit cards, and care credit. We do **NOT** accept checks. **Any outstanding balances will be sent to collections.**

Signature_____ **Date**_____