**TLC FOR PETS**
**11809 Reisterstown Road**
**Reisterstown, MD 21136**

# Patient/Client Information

Date _____          Pat. ID _____

Owner #1 Name _____Owner #2 (Spouse/Other)_____
Children in Home (Not Pets) First Names & Ages _____
Address _____
City _____ State _____ Zip_____

|  | Owner #1 Contact Information | Owner #2 Contact Information |
|---|---|---|
| Home Phone |  |  |
| Cell Phone |  |  |
| Work Phone |  |  |
| Employer Name |  |  |
| E-Mail Address |  |  |

Which phone is the best voice contact number? _____     Text? _____
Do you check voice messages regularly (Please Circle)?   Yes   No   Sometimes    Not Available
Non-Owner Emergency Backup Contact Name_____ Phone_____
*What information above is likely to change in the next year?_____*

We will gladly prepare a written estimate if you desire.  Please ask the receptionist or doctor.

Likely Method(s) of Payment (Please check all that apply):
___ Cash                              ___Personal Check-provide driver's license and Soc. Sec. #
___ Credit Card                         License & state_____
___ Debit Card                          Soc. Sec. Number_____

How did you hear about our hospital? (please check all that apply)
____ Have Been Here Previously          ____ Yellow Pages
____ Another Client _____     ____ Red Community Phone Book
____ Hospital Sign/ Location            ____ Maryland Pet Gazette
____ Internet- Our Website              ____ Know Doctor/Staff Member_____
____ Internet- Not our Website          ____ Other_____

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**Patient Information**
Name_____ Species and Breed_____
Age/Date of Birth_____ Color_____ Markings _____
Sex(circle):  Intact Male      Neutered Male     Intact Female     Spayed Female     Unknown
Does Pet Have Microchip or Tattoo Identification?   Yes      No      Unknown
Owned Since Date_____ Acquired From_____
Pet's Previous Records at What Facility ? _____
Previous Record Name of Owner &/or Pet if Different:_____
Other Pets in Household Names and Species:_____

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**I verify that all the information on this page is correct to the best of my knowledge. I am able to authorize services for the patient.  I agree that I am financially responsible for all services rendered and anticipate paying in full today.  I understand that fees shall be due when services are rendered at future visits as well.**

Signature of Owner (#1 or #2): _____ Date: _____