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

OWNER INFORMATION

Last Name	**First Name**		**Date**
Street Address			**Apt/Unit #**
City:		**State: SC**	**Zip:**
Primary Phone	**Work Phone(s)**		**Other Phone(s)**
Co-Owner Name Last	**Co-Owner Name First**		**Primary Phone**
Email			**Address**
How did you hear about us?	**Personal Reference**		**Who may we thank?**

How did you become aware of our Hospital? □ *Drove by* □ *Coupon* □ *Billboard* □ *Website / Internet*

All Fees Are Due At the Time Services Are Rendered.

We Accept: Visa, MasterCard, Care Credit, Checks and Cash

PET INFO

	PET # 1	PET # 2	PET # 3	PET # 4
Name				
Age/DOB (or best estimate)				
Species (Please Specify)	☐Dog ☐ Cat	☐Dog ☐ Cat	☐Dog ☐ Cat	☐Dog ☐ Cat
Breed				
Color				
Sex	□ Male □ Neutered □ Female □Spayed	□ Male □ Neutered □ Female □Spayed	□ Male □ Neutered □ Female □Spayed	□ Male □ Neutered □ Female □Spayed

I assume responsibility for all charges incurred in the care of this / these animal(s). I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment or hospitalization. Should my account become delinquent, I assume responsibility for all collection fees in addition to the amount of my bill. I am aware that the practice of medicine and other health care professions is not an exact science and I further state and understand that no guarantee has been or can be made as to the result of treatments or examination at WKVH

Owner or Responsible Party Signature

Please print your name