



Client Information Form

Welcome to Penryn Pet Hospital, please complete and return the following form. We look forward to working with you and your pets.

Owner: _____				
	First	Last	Phone	
Co-Owner: _____				
	First	Last	Phone	
Home Address: _____				
	Street	City	State	Zip
Mailing <input type="checkbox"/> <i>same as home address</i>				
Address: _____				
	Street	City	State	Zip
Email: _____			Current Client <input type="checkbox"/> YES	
Secondary Email: _____			at LBEMG: <input type="checkbox"/> NO	

Emergency Contact Name: _____	Phone: _____
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Pets Name: _____	Breed: _____	Species: _____
Age/DOB: _____	Color: _____	Male <input type="checkbox"/> Neutered <input type="checkbox"/> Female <input type="checkbox"/> Spayed <input type="checkbox"/>

Pets Name: _____	Breed: _____	Species: _____
Age/DOB: _____	Color: _____	Male <input type="checkbox"/> Neutered <input type="checkbox"/> Female <input type="checkbox"/> Spayed <input type="checkbox"/>

How did you hear about us?

- Friend/Family Referral
 Facebook
 Instagram
 Yelp
 Google/Search
 Community Event
 Email
 Hospital Sign
 Other: _____

____ I agree that photos of my pet(s) may be used for documentation, marketing, website, or other purposes.

I hereby authorize Penryn Pet Hospital to examine, prescribe for, treat, or perform surgery upon the above described pet(s). I also consent to the administration of such anesthetics as are necessary. Furthermore, I agree to pay fees for services rendered at the time the pet is discharged from the hospital or when service is otherwise terminated. I authorize the sharing of veterinary medical information between veterinarians or facilities for the purpose of diagnostics or treatment of my pet who is the subject of the medical records. I further understand that veterinary service may not be provided during the nighttime hours.

Owner Signature: _____ **Print Name:** _____ **Date:** _____