SHAFFER ANIMAL HOSPITAL
CLIENT/PET INFORMATION FORM

1475 E. Mitchell Hammock Rd
Oviedo, FL 32765
(407) 366-1722

Office Hours:
M-F 8:00 – 5:30
Sat 8:00 – 12:00

WELCOME to SHAFFER ANIMAL HOSPITAL

We appreciate your time and patience in giving us the information requested below to make you and your pet's visit the best possible.

CLIENT INFORMATION:

Name _____

Address _____

City _____Zip_____

Home Phone ( ) _____

Employer_____

Work Phone ( ) _____ext. _____

Email Address _____

Date _____

Spouse _____

Address _____

City _____Zip _____

Home Phone ( ) _____

Employer _____

Work Phone ( ) _____ext. ____

Email Address _____

PET INFORMATION: *(Please list all pets in the household)*

Name	Dog	Cat	Other	Breed	Color	DOB	Sex F/M	Spay	Neuter	Date of Last Vacc.
1										
2										
3										
4										
5										

What was Pet(s) last kind of treatment (exam, shots,etc.) _____

_____

Previous Veterinarian's Name _____

Can we request a copy of your records be sent to us? _____

How did you learn of our clinic? □ Yellow Pages □ Hospital Sign □ Recommendation □ Other_____

If by recommendation, name of person _____

ACCOUNT INFORMATION:

Please circle your preferred method of payment:

Cash *Check Visa MasterCard Discover

Florida Driver's License # _____

On your request, we will provide you with written estimate of fees for any treatment, emergency care, surgery or hospitalization that will be provided. A deposit prior to treatment may be required depending on the amount of the estimate. All fees are due at the completion of your pet's treatment. There will be a fee for any returned checks. The client agrees to pay attorney fees and all costs if Shaffer Animal Hospital retains an attorney to collect any fees due for treatment of services.

Owner's/Agent Signature _____