

RANDALL OAKS ANIMAL HOSPITAL

7014 HUNTLEY RD. CARPENTERSVILLE, IL 60110
847-428-8430

CLIENT INFORMATION

NAME: _____ SPOUSE/OTHER: _____
(Last) (First)

ADDRESS _____
(Street) (City) (State) (Zip)

HOME TELEPHONE: () COUNTY: _____

CELLULAR TELEPHONE: () _____

E-MAIL ADDRESS: _____

How did you hear about our practice? (circle one)

Yellow Pages Mailing Drive by Referred by: _____
Other: _____

NAME / PHONE NUMBER OF PREVIOUS VETERINARIAN: _____

Do you have pet insurance? (circle one) YES NO

If NO, would you be interested in information on pet insurance? (circle one) YES NO

FOR YOUR CONVENIENCE, WE ACCEPT CASH, CHECKS, AND MAJOR BANKCARDS (VISA, MASTERCARD, DISCOVER) AS FORMS OF PAYMENT. THE ABOVE LISTED CUSTOMER AGREES, BY SIGNING THIS AUTHORIZATION, TO PAY INTEREST AT THE RATE OF 1.50% PER MONTH, WHICH IS THE ANNUAL PERCENTAGE RATE OF 18%, ON ANY PAST DUE ACCOUNT, AND TO PAY THE REASONABLE ATTORNEY'S FEES AND COURT COSTS OF RANDALL OAKS ANIMAL HOSPITAL THAT ARE INCURRED IN THE COLLECTION OF ANY PAST DUE ACCOUNT.

I HAVE READ / COMPLETED THIS FORM, UNDERSTAND IT, AND AGREE TO ITS TERMS.

Signature: _____ Date: _____

Witnessed By: _____ (for staff use: Client ID# _____)

PET INFORMATION

1) Pet's Name _____ Dog / Cat / Other _____
Male / Female Spayed / Neutered / Intact Family pet / Breeding or Show Animal
Breed _____ Color _____ Birthdate _____
Current diet (type and amount fed) _____
Current medications _____
Previous health problems _____
Additional information _____
(for staff use: Patient ID# _____)

2) Pet's Name _____ Dog / Cat / Other _____
Male / Female Spayed / Neutered / Intact Family pet / Breeding or Show Animal
Breed _____ Color _____ Birthdate _____
Current diet (type and amount fed) _____
Current medications _____
Previous health problems _____
Additional information _____
(for staff use: Patient ID# _____)

3) Pet's Name _____ Dog / Cat / Other _____
Male / Female Spayed / Neutered / Intact Family pet / Breeding or Show Animal
Breed _____ Color _____ Birthdate _____
Current diet (type and amount fed) _____
Current medications _____
Previous health problems _____
Additional information _____
(for staff use: Patient ID# _____)