



Northstar Animal Care

Upper Arlington Veterinary Hospital

Date: _____

Client Information

Name: _____

Last

First

Middle Initial

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Work #: _____ Cell #: _____

E-Mail Address: _____

Secondary Owner: _____

Last

First

Middle Initial

Secondary Owner Phone #: _____

Name of any other person to authorize treatment: _____

Patient's Name: _____ Dog: _____ Cat: _____ Bird: _____ Other: _____

Breed: _____ Sex: M__ F__ Spay/Neutered: Y N

Date of Birth: _____ Weight: _____ Color/Markings: _____

Allergies: _____ Vaccines up to date? Y N

Rabies: 1 yr. _____ 3 yr. _____ Past Medical Problems: _____

Patient's Name: _____ Dog: _____ Cat: _____ Bird: _____ Other: _____

Breed: _____ Sex: M__ F__ Spay/Neutered: Y N

Date of Birth: _____ Weight: _____ Color/Markings: _____

Allergies: _____ Vaccines up to date? Y N

Rabies: 1 yr. _____ 3 yr. _____ Past Medical Problems: _____

How did you choose Northstar Animal Care or Upper Arlington Veterinary Hospital?

____ Referred by: _____

____ Noticed Sign by the Street ____ Yellow Pages ____ Internet

____ Other, Please Explain; _____

**Payment is due at the time of service. We accept the following forms of payment:

Cash, Check, Visa, Master Card, Discover, American Express, & Care Credit

*** I grant Northstar Animal Care/Upper Arlington Veterinary Hospital, its representatives and employees the right to take photographs of me and my pet. I authorize Northstar Animal Care/Upper Arlington Veterinary Hospital, and transferees to copyright, use and publish the same print and/or electronically. Including for example such purposes as publicity, illustration, advertising, and Web content.

I agree to the payment terms and certify the above information to be true,

Signature _____ Date _____

Thank you for choosing Northstar Animal Care & Upper Arlington Veterinary Hospital