



www.MyWestgateAnimalHospital.com
2135 N. Clairemont Ave, Eau Claire, WI 54703
Phone (715) 834-7538 Fax (715) 834-5880

CLIENT INFORMATION REQUEST

PLEASE CHECK ONE: NEW CLIENT CURRENT CLIENT-NEW PET

NAME _____
LAST FIRST MIDDLE INITIAL

ADDRESS _____
STREET CITY, STATE, ZIP CODE

SOCIAL SECURITY# _____ PHONE NO. _____

CELLULAR PHONE NO. _____

EMPLOYER _____ WORK PHONE _____

SPOUSE _____

EMPLOYER _____ WORK PHONE _____

*EMAIL ADDRESS: _____

*PLEASE ENROLL ME AS A REGISTERED MEMBER OF THE HOSPITAL WEBSITE: YES NO
AS A REGISTERED MEMBER I WILL BE ABLE TO:

- | Request appointments/boarding | Make better decisions about pets' health & well being | Notify of address change |
- | Discover ways to help your pet live a longer & healthier life | Inform if pet is lost/deceased |

*PLEASE SUBSCRIBE ME TO THE **FREE** PET LIVING & WELLNESS NEWSLETTER: YES NO

TOPICS OF INTEREST:
 DOGS CATS HORSES BIRDS REPTILES RODENTS DR/MEMBER ANNOUNCEMENTS

Please note: Your privacy is important to us.
All information received in all forms and through other communications is subject to our **Patient Privacy Policy**

HOW DID YOU FIRST HEAR OF US?

- PERSON'S NAME _____
- YELLOW PAGES
- NEWSPAPER
- INTERNET SEARCH ENGINE _____
- OTHER _____

PATIENT INFORMATION

PET NO. 1

PET NO. 2

NAME _____ NAME _____

BIRTH DATE OR APX. AGE _____ BIRTH DATE OR APX. AGE _____

SPECIES: _____ CAT _____ DOG _____ OTHER SPECIES: _____ CAT _____ DOG _____ OTHER

BREED _____ SEX _____ BREED _____ SEX _____

NEUTERED? _____ COLOR _____ NEUTERED? _____ COLOR _____

PREVIOUS ANIMAL HOSPITAL IF ANY _____

ANY PREVIOUS SERIOUS ILLNESSES OR SURGERIES? _____

ANY ALLERGIES TO VACCINATIONS OR MEDICATIONS? _____

IS YOUR PET ON ANY SPECIAL DIETS OR MEDICATIONS? _____

PLEASE LIST ANY OTHER INFORMATION THAT MAY ASSIST THE VETERINARIAN IN EVALUATION OF YOUR PETS HEALTH CONDITION:

I HEREBY AUTHORIZE THE VETERINARIANS TO EXAMINE, PRESCRIBE FOR, OR TREAT THE ABOVE DESCRIBED PET(S). I ASSUME RESPONSIBILITY FOR ALL CHARGES INCURRED IN THE CARE OF THIS ANIMAL. I ALSO UNDERSTAND THAT THESE CHARGES WILL BE PAID AT THE TIME OF RELEASE AND THAT A DEPOSIT MAY BE REQUIRED FOR SURGICAL TREATMENT.

SIGNATURE OF OWNER OR AGENT _____

METHOD OF PAYMENT: _____ CASH _____ CHECK _____ MASTERCARD _____ VISA
_____ DISCOVER _____ OTHER