WELCOME!

PET MEDICAL CENTER OF KATY

Thank you for giving our hospital the opportunity to care for your pet. To ensure the best service possible, please take the time to fill in this form completely.

Client Information

Name: ____

Street Address: ______________________________City/State/Zip: ____________________________

Home Phone: ____________________Cell: ____________________Fax: ________________

E-mail Address: ____

Employer: ____Work Phone: ____________________

Drivers License # :____________(necessary if paying by check)

Spouse/Partner Name: ____

Emergency Contact Person: ______________________ Phone Number: _______________________

Patient Information

Name:____________________	Name:____________________	Name:____________________
Date of Birth:______________	Date of Birth:______________	Date of Birth:______________
Breed:____________________	Breed:____________________	Breed:____________________
Color:____________________	Color:____________________	Color:____________________
Sex: MALE / FEMALE	Sex: MALE / FEMALE	Sex: MALE / FEMALE
Spayed/Neutered: YES / NO	Spayed/Neutered: YES / NO	Spayed/Neutered: YES / NO

How did you hear about us?

Friend/ Someone we may thank? _____________________

Ad ☐ Drive by ☐ Vet Referral ☐ Yellow Pages ☐ Internet ☐ Other:___________

**Full Payment is due upon rendering of services. Deposits may be required at the start of treatment for major medical procedures.
**To prevent the spread of infectious diseases and parasites, hospitalized or boarded animals must be current on vaccines according to hospital policy, and be free of internal and external parasites.

Signature: ______________________________ Date: ______________