

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: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell: _____ Fax: _____

Spouse/Partner Name: _____

E-mail Address: _____

Service / Appointment reminders
preference: (please check one)

Text

Email

Employer: _____ Work Phone: _____

Emergency Contact Person: _____ Phone Number: _____

Patient Information

Name: _____ Name: _____ Name: _____

Age/D.O.B.: _____ Age/D.O.B.: _____ Age/D.O.B.: _____

Breed: _____ Breed: _____ Breed: _____

Color: _____ Color: _____ Color: _____

Sex: MALE / FEMALE

Spayed/Neutered: YES / NO

Medical alerts and/or allergies:
YES / NO if yes, please note:

Sex: MALE / FEMALE

Spayed/Neutered: YES / NO

Medical alerts and/or allergies:
YES / NO if yes, please note:

Sex: MALE / FEMALE

Spayed/Neutered: YES / NO

Medical alerts and/or allergies:
YES / NO if yes, please note:

How did you hear about us?

Friend/ Someone we may thank? _____

Advertisement Drive by Online **If Online-What site?** _____ 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.

We love sharing photos of our new patients with our clients and public by posting pictures within the clinic and on-line, ie. Facebook.

May we have your permission to photograph your pet(s) for this purpose? YES NO

Signature: _____ Date: _____