OAKTON ANIMAL HOSPITAL

851 OAKTON STREET

ELK GROVE VILLAGE, IL 60007-1904

G. P. EPHRAIM, D.V.M.

CLIENT INFORMATION

(Please return this form completed and signed to the reception desk)

How did you first hear about us? ☒I Am a Returning Client ☒Web Yellow Pages ☒Groomer ☒Phone Book ☒Sign/Driving By ☒Our Web Site ☒Friend _____.

Please Tell Us Your Friend's Name. We'd like to thank them.

DATE: _____

NAME: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. _____

Last First

SPOUSE/SIGNIF. OTHER ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr._____

STREET ADDRESS: _____APT#./UNIT # _____

CITY: _____ZIP CODE: _____COUNTY: ☐ Cook ☐ DuPage ☐ Other _____

(Required for County Rabies Registration)

HOME PHONE NUMBER: (Please include area code) _____

CELL PHONE NUMBER: (Please include area code) _____

EMPLOYER: _____

WORK PHONE NUMBER: (Please include area code) _____

E-MAIL ADDRESS: _____

IN CASE OF EMERGENCY, CONTACT _____

EMERGENCY PHONE NUMBER: (Please include area code) _____

Patient Information

Dog ___ Cat ___ Other _____ How many pets in your household? _____

Name _____ Age of Pet_____ Lived with you since _____

Breed _____ Color _____ Male _____ Female _____ Neutered _____

Current on yearly vaccinations? ☐ Yes (*Date given* ____/____/____*)* ☐ No ☐ Not sure Pertinent current/Previous Medical Conditions: _____

_____

_____

Full payment is required at time of service. If your pet is hospitalized, full payment will be required at the time of his/her release. Visa/MasterCard/Discover/American Express/ Trupanion Express Pay/Care Credit accepted.

For quality assurance and security purposes, our hospital uses audio recording for appointments and phone calls, as well as audio/video recording on-site. By scheduling an appointment or contacting us, you consent to this recording.

I have read the preceding statements and understand their meaning.

Signature of owner _____ Date ___/___/___