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	Sex: MALE / FEMALE Spayed/Neutered: YES / NO	Sex: MALE / FEMALE Spayed/Neutered: YES / NO
Medical alerts and/or allergies: YES / NO if yes, please note:	Medical alerts and/or allergies: YES / NO if yes, please note:	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: _____