Dr. Lang's Orofino Animal Clinic

807 Michigan Ave.
P.O. Box 2565
Orofino, ID 83544
(208) 476-5995

PATIENT AND CLIENT INFORMATION SHEET

Thank you for giving Orofino Animal Hospital the opportunity to care for your pet. So that we may become better acquainted, please complete the following:

Mr.
Mrs.
Dr.
Ms. OWNER(S) _____ SPOUSE'S _____
LAST FIRST INITIAL LAST FIRST INITIAL

SS# _____ SS# _____

MAILING ADDRESS _____
STREET CITY STATE ZIP CODE

RESIDENCE PHONE _____ WORK PHONE _____ SPOUSE'S WORK PHONE _____

RESIDENCE CELL PHONE _____ SPOUSE'S CELL PHONE _____

PLACE OF EMPLOYMENT _____ / _____ ADDRESS _____
EMPLOYER TITLE

SPOUSE'S PLACE OF EMPLOYMENT _____ / _____ ADDRESS _____
EMPLOYER TITLE

IF NECESSARY, MAY WE CALL YOU AT WORK? ❑ YES ❑ NO

HOW DID YOU BECOME AWARE OF OUR HOSPITAL?

❑ YELLOW PAGES ❑ HOSPITAL SIGN ❑ OTHER

❑ PERSONAL RECOMMENDATION - WHO MAY WE THANK? _____
NAME

PET INFORMATION (Please fill in the following for each pet.)

	PET 1	PET 2	PET 3
NAME			
SPECIES (cat, Dog, Other)			
BREED			
DESCRIPTION			
DATE OF BIRTH			
SEX			
ALTERED?			

All fees are due upon release of patient. Please indicate your choice of payment.

❑ Cash ❑ Check (Driver's License required) ❑ MC/VISA

_____
CLIENT'S SIGNATURE

Again, thank you for giving us the opportunity to serve you.