Welcome to Ark Animal Hospital

2616 Mission St. Santa Cruz, CA 95060
Christina Hoefer, DVM

CLIENT INFORMATION FORM

Thank you for giving us the opportunity to care for your pet(s).
So that we may become better acquainted, please complete the following:

Owner 1 Information	Owner 2 Information
Name:	**Name:**
Address:	**Address:**
City, State, Zip Code:	**City, State, Zip Code:**
Phone: Please circle number to call first **Home:** **Cell:** **Work:**	**Phone: Please circle number to call first** **Home:** **Cell:** **Work:**
Email:	**Email:**
Occupation:	**Occupation:**
How did hear about us?	

****All Fees Are Due At The Time Services Are Rendered ****

Pet's Name:_____ Breed:_____ Color:_____
Species:_____ Sex: M F Altered: Y N Birthdate:_____
Last Vaccination: Rabies:_____ Other:_____

Any previous serious illnesses or surgeries? _____

Any allergies to vaccinations or medications? _____

Is your pet on any special diets or medications? _____

I hereby authorize the staff of Ark Animal Hospital to perform any treatment which is deemed necessary to my pet(s) health while in custody of the hospital. I understand that in the event of any unusual emergency circumstances, the staff will make every attempt to contact me or my designated representative before, if time permits, proceeding with treatment. I understand that I will be financially responsible for all emergency procedures including the Estimate of charges provided to me in person or over the telephone**. I understand that all fees are to be paid at the time services are rendered and a deposit is required on all pets admitted to the hospital.**

Signature____ Date__________________