



Welcome!

So that we may become better acquainted with your pet, please complete the following form.

601 Kasold Dr. D-105, Lawrence KS, 66049 (785)841-1919
www.gcahlawrence.com

CLIENT INFORMATION

Name: _____

Local Address: _____ City: _____ Zip: _____

Permanent Address: _____ City: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Best time to reach you: _____ E-mail: _____

Drivers License #: _____ Employer: _____

Spouse/Other: _____

Cell: _____ Work Phone: _____ DL #: _____

Rate preferred method for reminders and health updates. Phone__ Text__ Email__ Postcard__

Clients receive a thank-you credit for referrals. Whom may we thank for sending you to us?

Name of Friend/Relative: _____

PATIENT INFORMATION

Name: _____ (Dog or Cat) (M or F) (Spay or Neutered)

Date of Birth/Age: _____ Breed: _____ Color: _____

Are vaccines current? Yes: __ No: __ Date/ Hospital performed at: _____

Allergies to vaccines or meds: _____ Special diets or meds: _____

Any previous serious illness or surgeries? _____

Type of heartworm prevention *currently* on: _____

Type of flea and tick prevention *currently* on: _____

ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED

Please circle choice of payment: Check Cash VISA Discover Mastercard Care Credit

Understanding that ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED, I authorize treatment for my pet. I also understand that a deposit is required for in-hospital treatment.

Signature of owner or responsible party: _____ **Date** _____