Date: _____
Client #: _____

Pilot Knob Animal Hospital

4145 KNOB DRIVE • EAGAN, MINNESOTA 55122 • (651) 452-8160

Welcome to Pilot Knob Animal Hospital!!

Please provide the following information to create your family's medical record:

CLIENT INFORMATION

Name _____ Spouse's Name _____

Address _____City _____ State _____ Zip Code _____

□Home Phone _____ □Cell Phone _____ □Work Phone _____

□Email _____ Would you like email reminders? □Yes □No

Please check the preferred form of contact above.

Alternative Contact/Spouse's Phone _____

PATIENT INFORMATION

Name _____

□ Canine □ Feline □ Other

Breed _____

Date of Birth _____

Color/Markings _____

□ Male □ Female □ Spayed/neutered

Previous Clinic & City _____

_____

Name _____

□ Canine □ Feline □ Other

Breed _____

Date of Birth _____

Color/Markings _____

□ Male □ Female □ Spayed/neutered

Previous Clinic & City _____

_____

REFERRAL INFORMATION

How did you learn about our clinic?

□ Referred by (name) _____ □ Internet □ Drove by □ Mailer □ Humane Society
□ Phone Book □ American Association of Feline Practitioners (AAFP) □ Other Clinic □ Other _____

Date: _____
Client #: _____

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PHOTO RELEASE FORM

I grant to Pilot Knob Animal Hospital, its representatives and employees the right to take photographs of me and/or my pet, and to copyright, use and publish the same in print and/or electronically.

I agree that Pilot Knob Animal Hospital may use such photographs of me and/or my pet with or without my name and for any lawful purpose, including, for example, such purposes as publicity, illustration, advertising, and Web content.

- The above may take photos of me and/or my pet
- The above may **NOT** take photos of me and/or my pet

PAYMENT INFORMATION

We accept cash and all major credit cards. Care Credit is accepted on invoices greater than $500.
Please indicate your payment preference: □ Cash □ Visa □ MasterCard □ Discover □ American Express

I verify that I am the legal owner of the animals identified on this form and am responsible for all medical decisions and payments at the time of service.

I authorize the following person(s) to make medical decisions on my behalf:

□ No One

Name _____ Phone # _____

Name _____ Phone # _____

Signature: _____ Date: _____