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: _____