WELCOME TO HAWTHORNE

Thank you for giving us the opportunity to care for your pet. To insure the best care possible, please take the time to fill out this form completely.

Today's Date: _____

Responsible Party/Owner Last Name: _____ First Name: _____

Spouse or Additional Contact(s) _____ _____

Street Address _____

City _____ State _____ Zip _____ County _____

Email Address _____

Primary Contact Number _____ Secondary Contact Number _____
(Main number to contact you regarding services/lab work, etc)

Text Messaging Number_____ ☐ I authorize Hawthorne to send me text messages.
(To receive lab results, surgery updates and other messages from Hawthorne. Messaging and data rates may apply.)

Emergency Contact Name _____ Phone _____

How did you learn of our clinic? ☐ I am a current client ☐ Client Referral _____

☐ Facebook ☐ Website ☐ Other _____

*** ☐ **I am a Referral from my regular DVM** Name of Hospital/Clinic _____

Referring Dr. _____

☐ Yes, I want my pet's medical notes and diagnostic results from this and all other visits sent to my regular DVM.

☐ No, please do not send any medical records to my regular veterinarian from this or any other visit.

PET HEALTH HISTORY

Name of Pet _____ ☐ Dog ☐ Cat ☐ Other _____

Breed _____ Color _____ Birth date _____

☐ Male ☐ Male Neutered ☐ Female ☐ Female Spayed

Vaccine History (Date): Rabies _____
DHPPC/FVRCP _____
Bordetella/Leukemia _____
Other _____

What veterinarian administered vaccines? _____

****Reason for Visit _____****

Please list any symptoms or problems that you have noticed about your pet :

__ Behavior Problems __ Lack of Appetite __ Sneezing __Bleeding Gums __Limping __Vomiting
__ Breathing Problems __ Coughing __ Diarrhea __Gagging __ Scooting __ Weakness
__ Loss of Balance __ Scratching __ Increased Urination and/or Thirst __ Shaking Head __ Depressed

__ Other _____

AUTHORIZATION

I hereby authorize the veterinarian (Hawthorne Animal Hospital) to examine, prescribe for, or treat the above described pet. I assume all responsibility for all charges incurred in the care of this animal. Please note that payment is required in full at the time services are rendered. Any service not paid in full are subject to a 1.5% monthly service fee ($2.00 minimum). Any account turned over to collections will be responsible for any additional fees. We will gladly provide you with a written estimate if you desire.

Signature of Responsible Party _____ Date _____