

**Northwoods Animal Hospital**  
980 Northwoods Drive  
Cary, NC 27513

Thank you for giving Northwoods Animal Hospital the opportunity to care for your pet. So that we may become better acquainted, please complete the following:

Owner \_\_\_\_\_ Spouse/Co-owner \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Driver's License \_\_\_\_\_ State Issued \_\_\_\_\_  
Email address: \_\_\_\_\_ (for internal use only)  
Spouse/Co-Owner Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

How did you first become aware of our hospital?

\_\_\_\_\_ Yellow Pages  
\_\_\_\_\_ Talking Phonebook  
\_\_\_\_\_ Hospital Sign/Location  
\_\_\_\_\_ Internet  
\_\_\_\_\_ Personal Recommendation- who may we thank? \_\_\_\_\_

**Pet Information**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Species: Canine \_\_\_\_\_ Feline \_\_\_\_\_ Mustelidae \_\_\_\_\_ Other \_\_\_\_\_  
Breed \_\_\_\_\_ Color \_\_\_\_\_ Sex (spayed/neutered) \_\_\_\_\_  
Major medical problems \_\_\_\_\_  
Are vaccinations current? Yes (date given) \_\_\_\_\_ No \_\_\_\_\_  
List any known drug allergies that your pet has \_\_\_\_\_  
List any medications or special diets your pet is on \_\_\_\_\_

What health care products are you currently using? \_\_\_\_\_  
Reason for today's visit? \_\_\_\_\_

I authorize Northwoods Animal Hospital to examine and provide treatment for the above described pet, and agree to be responsible for payment of any charges incurred. I understand that the hospital's policy is that payment in full is due when services are rendered and therefore agree to pay for all services at the time the pet is discharged. Please indicate the method of payment:

\_\_\_\_\_ Cash \_\_\_\_\_ Check \_\_\_\_\_ Visa \_\_\_\_\_ MasterCard \_\_\_\_\_ Discover Card \_\_\_\_\_ AmEx

It is our policy to provide you with a written estimate of fees upon request for any case requiring emergency care, surgery or hospitalization. A deposit prior to treatment may be required depending on the amount of the estimate.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_  
Hospital Representative \_\_\_\_\_ Date \_\_\_\_\_

Again, thank you for giving us the opportunity to serve you.