

WELCOME TO THE CAT HOSPITAL OF ORLANDO

Revised 10-12-11 jrs

OWNER INFORMATION:

NAME: _____
LAST FIRST M.I.

ADDRESS: _____
STREET APT.

CITY STATE ZIP

HOME PHONE: _____ CELL PHONE: _____

EMPLOYER: _____ WORK PHONE: _____

Email Address: _____

Please list the names of any other individuals you authorize as a contact regarding your cat. If none are listed, you will be the only person we will contact, release information or discharge your cat to.

NAME(S)

PHONE

HOW DID YOU FIND The Cat Hospital of Orlando? _____

YOUR CAT'S INFORMATION

	CAT #1		CAT #2		CAT #3	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
	INDOOR	OUTDOOR	INDOOR	OUTDOOR	INDOOR	OUTDOOR
	BOTH		BOTH		BOTH	
CAT'S NAME						
BREED & COLOR						
AGE OR DATE OF BIRTH						
SPAYED OR NEUTERED	Yes	No	Yes	No	Yes	No
DATE OF LAST VACCINATIONS						
CLINIC NAME						
CLINIC PHONE NUMBER						
SPECIAL DIETS AND MEDICATIONS						
PREVIOUS ILLNESS/ SURGERY						

Has your pet previously been Feline Leukemia and FIV tested _____

FINANCIAL POLICY

It is our policy that payment is due at the time services are rendered. **Per The Federal Trade Commission, and under the Fair and Accurate Credit Transaction Act of 2003, we are not permitted to extend credit to clients or to charge on account.** Please initial here that you are aware of this policy. _____ If you are not the owner, and are an agent authorized by the owner, do you accept responsibility for payment in full? (circle) YES NO

Signature _____ Date: _____

**We gladly accept: Cash, MasterCard, Visa, Discover and Care Credit.
We will only accept checks from established clients.**