



Eric Lange, DVM
Rebecca Walker, DVM

Welcome to Our Hospital

So that we become better acquainted, please complete the following:

Owner _____ Spouse/Co-Owner _____
Last First Initial Last First Initial

Address _____
Street City Zip

Telephone _____
Home Cell Work

Employment _____
Employer Title Address

Email Address _____

Spouse / Co-Owner Employer _____ Phone _____

The following information must be provided if you intend to pay by check. Without this information, only credit card and cash transactions will be accepted.

Social Security # _____ Date of Birth _____

Driver License No. _____ State _____ Expiration Date _____

Do you plan to pay by: Cash Check Visa / MasterCard American Express Discover

I understand that all fees are to be paid at the time services are rendered.

Signature _____ Date _____

We will be happy to provide you, upon request, a written estimate of fees for any case where in-hospital treatment, emergency care, surgery or hospitalization will be needed. A deposit prior to treatment is required.

Please tell us about all of your pets:

Pet's Name	Sex F / M	Breed	Neutered? Yes / No	Color / Markings	Date of Birth	Date of Last Vaccinations