Animal Hospital of Lynnwood
19503 56th Avenue West
Lynnwood , WA 98036-5980
Phone : (425) 771-6300 Fax : (425) 672-1107

Animal Wellness & Rehab Center
2115 112th Avenue N.E. # 100
Bellevue, WA 98004
Phone : (425) 455-8900 Fax : (425) 455-9946

"Thank you for giving us the opportunity to care for your pet. Please help us to meet your needs better by taking a moment to complete this information"

How did you hear about us?
☐ Veterinary Practice ☐ Website ☐ Google
☐ Sign/Drive by ☐ Yahoo ☐ Yellow Pages/Dex
☐ Personal Recommendation (Whom may we thank?)_____
☐ Other_____

CLIENT INFORMATION				Date:
Owner:		Co-Owner:		
Address:		City:	State:	Zip:
Phone:		Cell:		
Place of Employment:		Work Phone:		
E-mail address:				
SSN# /Driver License :(if paying by check)				

PATIENT INFORMATION	PET NUMBER 1	PET NUMBER 2	PET NUMBER 3	PET NUMBER 4
Name:				
Species : Canine or Feline				
Breed:				
Color/Marking:				
Gender: (Spayed or Neuterd)				
Date of Birth:				

PAYMENT INFORMATION

PLEASE READ CAREFULLY AND SIGN BELOW

I understand that every effort will be made to achieve a successful outcome and to provide for all possible safety in hospital care and handling. I hereby authorize this hospital to receive, prescribe for, treat, and/or perform surgery upon the pet(s) that I present. We will gladly prepare a written estimate at any time that you may so desire, just ask a receptionist, technician, or doctor. Professional fees are due at the time services are rendered. Furthermore, I agree to pay for services rendered at the time the pet is discharged from the hospital or when the service is terminated. I agree to pay any and all reasonable costs of collection in the event that collection efforts become necessary. I understand that a service fee of $25.00 will be assessed for each non- sufficient fund check and / or certified letter that must be sent.

To prevent the spread of infectious diseases, all hospitalized and boarded patients must be current on all vaccines and free from internal and external parasites. The signature below authorizes this level of preventative care and the appropriate charges will be assessed in the discharge invoice.

Please indicate your choice of payment:
□ Cash □ Check □ Debit Card □ Credit Card

Signature of Owner or Authorized Agent:_____ Date_____