Elma Animal Hospital
3180 Transit Road
West Seneca NY 14224
Phone (716) 656-7387

Client Information:

Name: _____

Address: _____

City/Town: _____

Zip:_____ Pharmacy:_____

Home Phone:_____Work Phone:_____

Cell Phone:_____Email:_____

Employer Name/Address_____

Driver's License#_____

Do you have a preferred Veterinarian? _____

Served in the Unites States Military? Y/N_____Branch:_____

Authorized agent(s): I_____, give my permission to the following to act as the authorized agent and be able to make decisions and receive any information regarding my pet(S) that are being treated at Elma Animal Hospital PC:

Name:_____ **Name:**_____

Date: _____

Referral: How did you hear about our hospital? _____

Was it a staff member? Y/N_____Who? _____

Previous Veterinarian: _____

Any Known Allergies? _____

Previous Vaccine Reaction? Y/N

Current Medications? _____

Medical Conditions/Problems? _____

_____

Patient Information:

Name: _____Birthday:_____

Species: Dog_____ Cat_____ Reptile_____ Sm. Mammal_____

Aquatic_____ Breed:_____

Sex:_____ Spayed:_____ Neutered:_____Color:_____

Microchip#:_____

Name: _____Birthday:_____

Species: Dog_____ Cat_____ Reptile_____ Sm. Mammal_____

Aquatic_____ Breed:_____

Sex:_____ Spayed:_____ Neutered:_____Color:_____

Microchip#:_____

Name: _____Birthday:_____

Species: Dog_____ Cat_____ Reptile_____ Sm. Mammal_____

Aquatic_____ Breed:_____

Sex:_____ Spayed:_____ Neutered:_____Color:_____

Microchip#:_____

We appreciate your patience in completing this form. It allows us to improve our customer service.

Financial Information:

PROFESSIONAL FEES ARE DUE AT TIME OF SERVICE.

How will you be paying today? Cash_____ Visa_____M/C_____

Discover_____ American Express_____

Personal checks are NOT accepted.

I the undersigned, and owner or authorized agent of the above mentioned pet(s), do hereby authorize Elma Animal Hospital PC to perform such examinations, diagnostic tests, and treatments as necessary. I further agree to be financially responsible for all costs for such procedures and treatments. I understand that full payments is due at the time services are rendered. I understand that abandonment of animals does not relieve me of this financial obligation. I further understand that failure to pay on time may result in a monthly charge of 2.5% interest and $7.00 billing fee.

Signature:_____**Date:**_____

Elma Animal Hospital

Request for Transfer Of Medical Records

Niagara Frontier Medical Society

By law, original medical records must be retained for five years after the last entry. However, a copy or summary of the information contained in these records can be forwarded. The confidentiality of your pet's records is very important. Accordingly, we ask you sign where indicated to authorize the release of your pet's medical information.

CLIENT NAME: _____

ADDRESS: _____

_____

_____

PHONE: _____

PET'S NAME: _____ DATE OF BIRTH: _____

Circle One: CAT DOG OTHER

(Please complete a separate form for each pet)

I authorize the release of a copy of the medical records for the above animal.

FROM: _____

TO: Elma Animal Hospital 3180 Transit Road West Seneca, NY 14224

Phone: 716-656-7387 Fax: 716-656-6059 Email: Elmavets@gmail.com

Pet Owners Signature: _____

☐ Check here if this is a permanent transfer and you no longer wish to receive mailings from your previous hospital.