

Jefferson Animal Hospital & 24 Hour Regional Emergency Center

4504 Outer Loop, Louisville, KY 40219 (502) 966-4104

Owner Information

Name: _____
Address: _____
City/State/Zip: _____
Home Phone: (____) _____
Cell Phone: (____) _____
Email Address: _____
Occupation _____
Place of Employment: _____
Employment phone: (____) _____

Date: ____/____/____

Spouse/Co-owner: _____
Phone: (____) _____
Email Address: _____
Occupation _____
Place of Employment: _____
Employment phone: (____) _____

How did you hear about us: _____
Person/Friend that we may thank: _____
Regular Veterinarian referred / answering machine: _____
Outside sign: ____ Website: ____ Yellow Pages: ____ Other: _____

PET Information

Name: _____
Sex: Male Female
Neutered / Spayed: Yes No
Age: _____ Date of Birth _____
Species: Dog ___ Cat ___ Other _____
Breed: _____
Color: _____
Length of time owned pet: _____
Adopted pet from: _____
Or Found Pet: _____
Regular Veterinarian: _____
Clinic: _____
Last visit date: _____ Reason: _____

Vaccine / Testing History:

Dog Vaccine	Date	Cat Vaccine	Date
DHPP (Distemper combo)	_____	FVRCP(Distemper combo)	_____
Rabies	_____	Rabies	_____
Bordetella	_____	FeLV(Feline Leukemia)	_____
Leptosporosis	_____	Other: _____	_____
Other: _____	_____	FeLV/FIV test	_____
Heartworm test	_____	Deworming	_____
Deworming	_____		

Medications: _____
Flea Product : _____ Date _____ Heartworm Preventative: _____ Date _____
Brand of food: _____ Current appetite: _____
Habitat: Indoor / Outdoor / Both Travels: Yes / No Exposure to Wooded Areas: Yes / No
Previous illness or surgery: _____
Main concern this visit: _____

Responsible Owner Agreement

I agree and understand that it is the policy of this hospital to receive payment as services are rendered and that a deposit will be required upon admission to our hospital for patient treatment.

I state that I am over 18 years old and am the responsible owner of this pet and represent any and all other owners.

Date: _____ Signature: _____

Method of Payment

Cash _____ Check _____ Credit Card _____ Debit Card _____ Care Credit _____

We accept Cash, TeleCheck approved Check, Visa, MasterCard, AmericanExpress, Discover, Debit Cards, CareCredit

Information required for Check payment OR Hospitalization:

Driver's License #: _____ Driver's License #: _____
Date of Birth: _____ Date of Birth: _____
Social Security # _____ Social Security # _____