Boston Heights
Veterinary Hospital

7040 Walter Rd
Hudson, Ohio 44236

Welcome to the Boston Heights Veterinary Hospital. Please complete this form so that an inclusive medical record can be prepared for your pet(s). Thank you.

Client Information: **Client ID:**

Owner's Name _____Spouse's Name_____

Street Address _____ City_____State_____, Zip _____

Email Address _____

Primary Contact# (_____)_____ Home / Cell (name_____) Secondary Contact# (_____)_____ Home / Cell (name_____)

Owner's Place of Employment _____ Business Phone (_____)_____

Animal Information:

Name _____ Birth Date _____ Sex ____ Neutered? _____ Breed _____ Color _____
Date of Last Vaccines _____Previous Veterinarian _____

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Please list any prolonged health problems:
Name: Condition(s) _____

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Policies:

If requested, an estimate of fees will be provided for any case where in-hospital treatment, emergency care, surgery, or hospitalization will be provided. For hospitalization, grooming or boarding, all fees must be paid at the time the animal is discharged. We accept cash, check, VISA, MasterCard, Discover and American Express.

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

Signature _____ Date _____