SUNSHINE
Animal Hospital

2800 Rock Creek Circle
Superior, CO 80027 303-499-0199 info@sunshineahofco.com

Client Name: _____ Pet #1 Name: _____Age/Birth Date: _____

Partner Name: _____ Species: _____ Breed: _____ Color: _____

Address: _____ Sex: _____ Spayed/Neutered: _____

_____ Allergies/Medical Concerns: _____

Home Phone: _____ Pet #2 Name: _____Age/Birth Date: _____

Cell Phone: _____ Species: _____ Breed: _____ Color: _____

Partner Phone: _____ Sex: _____ Spayed/Neutered: _____

E-mail Address: _____ Allergies/Medical Concerns: _____

Who can we contact to obtain previous medical/vaccine history? _____

How did you hear about us? _____

Do we have permission to send your pets records in the event they are requested by another facility? _____

Help us customize your visit

Are there any peanut allergies in your household? (Please circle): Yes No

Can we post photos of your pet on our website/social media? Yes No

Is your pet aggressive towards other animals? Yes No

Has your pet ever shown aggression towards people during a vet visit? Yes No

On a scale of 1-10, 1 being not anxious at all, how anxious is your pet about coming to the vet?

1 2 3 4 5 6 7 8 9 10

Do you need an ADA compliant entrance or help getting into the building? Yes No

Does your pet have trouble with slippery floors? Yes No

What is your preferred communication method? E-mail Phone Text

Do you prefer to check out at the front desk or in the exam room? _____

Does your pet have any food allergies? If so, what? _____

Does your pet have a favorite treat? If so, what? _____

I understand that I am responsible for all professional and hospital fees, including fees for medications and diagnostic procedures, and agree to pay, in full, for all services at the time they are rendered. This responsibility continues in the event my pet fails to recover, dies, or is euthanized. I am encouraged to discuss all fees attendant to the care of my animal before services are rendered, and to request a written estimate of involved fees if one has not been provided to me. Any verbal or written estimate of charges or fees is only a best approximation, and the final charges may be less than or greater than this amount. I agree to pay, upon request, a deposit of 50% of the estimated fees for hospitalization or admittance for a surgical or dental procedure, and to pay for the balance of all services rendered on a cash, credit card or check basis upon discharge.

_____ _____

Signature Date