



LAKEVIEW VETERINARY HOSPITAL, INC.
6245 Memphis Street
New Orleans, LA 70124
(504) 482-2173 www.lakeviewvet.com

Thank you for giving Lakeview Veterinary Hospital the opportunity to care for your pet.
So that we may become better acquainted, please complete the following:

PRIMARY OWNER: (Person financially responsible and responsible for health decisions)

Mr.,Mrs.,Ms.,Dr. Last _____ First _____ MI _____

SOCIAL SECURITY # _____ DRIVER'S LICENSE# _____

CHILDREN (& AGES): _____

ADDRESS: _____
Street Address _____ City _____ State _____ Zip Code _____

OWNER'S PHONE _____ CELL _____ E-MAIL ADDRESS: _____

PLACE OF EMPLOYMENT: _____ TITLE _____

If necessary, may we contact you at work? Yes or No

EMPLOYER'S ADDRESS: _____ WORK PHONE _____

Co-Owner Spouse _____

Does this person listed have permission to make decisions concerning your pets. Please check box if yes.

CO-OWNER'S PHONE _____ CELL _____ WORK _____

CO-OWNER/SPOUSE'S PLACE OF EMPLOYMENT: _____

TITLE _____ EMPLOYER'S ADDRESS: _____

If necessary, may we contact Co-Owner/Spouse at work? Yes or No

How did you become aware of our Hospital?

Personal recommendation: Whom may we thank? _____

Internet-Please specify (Google, Yelp, etc.) _____ Hospital sign Other _____

All Fees Are Due At The Time Services Are Rendered. We accept Visa, MasterCard, Discover, American Express and CareCredit credit cards as well as cash ,personal checks and Debit cards. Any balances carried at Lakeview Veterinary Hospital, Inc. will be charged a monthly service charge on all accounts over 30 days and a statement fee of \$6.00.

To prevent the spread of infectious disease and parasites, all in-patients, out-patients, boarders and grooming pets must be current on all vaccines and be free of parasites. I understand this to be the strict policy of the clinic and authorize the doctors to provide my pet or pets with vaccinations and parasite control as needed.

_____ * I give permission for Lakeview Veterinary Hospital to use photos of pets on our website or social media.

Signature _____ Date _____

So that we are able to suit your individual needs – which do you feel most applies to you:

Check One:

- I feel that my pet is another member of my family.
- I feel that my pet is just a pet.

Check One:

- I want the best medical care available for my pet. Please recommend anything that you feel is necessary for good health.
- I want good medical care for my pet, but there is a limit to what I am able to have done. I want you to perform only the services that I request.

Check One:

- I want to learn as much as I can about pet health care, please explain in detail what has been done for my pet or what is needed.
- I would prefer you just summarize what has been done for my pet or what is needed.
- I want my pet healthy, but don't need to know what has been done.

Check One:

- I prefer to be present when my pet is examined and treated.
- I would rather not see my pet examined and treated.

What prior illness or surgery should we know about? _____

Is your pet currently on a special diet or medication? (Please explain) _____

PET INFORMATION (Please fill in the following for each pet.)

	PET 1	PET 2	PET 3
NAME			
SPECIES			
BREED			
DESCRIPTION			
DATE OF BIRTH			
SEX			
ALTERED			
DATES VACCINATED			
MICROCHIP			

Again, thank you for giving us the opportunity to serve you