Jefferson Animal Hospital & 24 Hour Regional Emergency Center

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

Owner Information

Name: _____ Date: _____/_____/_____

Address: _____

City/State/Zip: _____

Home Phone: (_____)_____ Spouse/Co-owner: _____

Cell Phone: (_____)_____ Phone: (_____)_____

Email Address: _____ Email Address: _____

Occupation _____ Occupation _____

Place of Employment: _____ Place of Employment: _____

Employment phone: (_____)_____ 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:_____	_____		
Heartworm test	_____	FeLV/FIV test	_____
Deworming	_____	Deworming	_____

Medications: _____

Flea Product :_____ Date_____ Heartworm Preventative:_____Date _____

Brand of food: _____ Current appetite: _____

Habitat: Indoor ☐ Outdoor ☐ Both ☐ Travels: Yes 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, Care Credit

Information required for Check payment OR Hospitalization:

Driver's License #: _____ Driver's License #: _____

Date of Birth: _____ Date of Birth: _____

Social Securtiy # _____ Social Securtiy # _____