



GLENVIEW ANIMAL HOSPITAL

David A Cohen, DVM

Manny Kanter, DVM

Sarah Mateles, VMD

NEW PATIENT & CLIENT INFORMATION

Welcome to The Glenview Animal Hospital. So we may provide you with exceptional service, please share information about you and your pet(s). Our mission is to provide our clients with the very best loving, compassionate veterinary health and wellness care from before hello to beyond good-bye.

CLIENT INFORMATION

First name _____ Last name _____

Spouse first name _____ Spouse last name _____ County _____

Address _____ City _____ State _____ Zip _____

Best phone number to reach you at:

1. _____ Name: _____ Home Cell Work
2. _____ Name: _____ Home Cell Work
3. _____ Name: _____ Home Cell Work

E-mail address _____

PATIENT INFORMATION

Pet's name: _____ Sex: Male Female Neutered or spayed? Yes No

Species: Dog Cat

Pet's Date of Birth ____/____/____, or Age ____ Breed _____ Color _____

How did you become aware of the Glenview Animal Hospital?

Drove by Internet: Our website Nextdoor Facebook Other Site: _____

Other: Please specify _____

Referred by friend Whom may we thank? _____

Returning Client

We appreciate payment when services are rendered. For your convenience, we accept cash, check, MasterCard, Visa, American Express and Discover.

Which method you will be using: Cash _____ Visa/Master Card _____
Check _____ Discover _____ Am. Express _____

Authorization for examination, treatment, photos, and assumption of financial responsibility

I hereby authorize the veterinarian to examine, prescribe for and/or treat the above described pet. I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment. To prevent the spread of infectious diseases and parasites, hospitalized animal must be current on all vaccines and free of internal and external parasites. Any photographs taken of my pet along with my name may be used in electronic or printed material for publicity or advertising purposes.

Owner/Agent Signature: _____ Date: _____ Staff initials _____

2400 Waukegan Road Glenview, IL 60025

P: 847.724.4812

F: 847.724.4855

info@glenviewanimalhospital.com

www.glenviewanimalhospital.com