



CLIENT # _____

SEGUIN

ANIMAL HOSPITAL

LET'S GET ACQUAINTED!

*Thank you for giving Seguin Animal Hospital an opportunity to care for your pets.
So that we may become better acquainted, please complete the following.*

OWNER INFORMATION:

Name _____
Last First MI Title

Address _____
PO Box Physical Street Address

City _____ State _____ Zip _____ County _____

Phone #'s () _____
Home # Cell# Email Address

_____ () _____ Your Date of Birth: _____
Work Name Work Number

Social Security # _____ - _____ - _____ Drivers Lic # _____

SPOUSE INFORMATION:

Name _____
Last First MI Title

Work Name _____ (_____) _____
Work Number

Social Security # _____ - _____ - _____ Drivers Lic # _____

Date of Birth _____

In Case of Emergency please call: _____ @ (_____) _____ - _____

How did you learn of our hospital? ___Clinic sign ___Internet ___Website ___Facebook
___Newspaper ___Another veterinarian _____

If recommended, by whom? We would like to thank them! _____

How do you consider your pets? ___As part of the family ___Just as Pets

Clinic policies:

A) All fees are due at time of service. We do not offer payment arrangements, however we do accept Care Credit.

I have read and understand these policies:

Signature: _____ **Date:** _____



SEGUIN
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Seguin Animal Hospital
1252 W. Kingsbury
Seguin, TX 78155

830-379-3821
830-379-8481 fax
seguinah@hotmail.com

MEDICAL RECORDS RELEASE FORM

In accordance with the Veterinary Practice Act regarding the confidentiality of patient medical records, "a written authorization or other form of waiver executed by the client or an appropriate court order or subpoena" is required in order for us to provide a copy of your pet's medical records.

I certify that I am the owner of the patient(s) named below or that I am acting as a legal agent for the owner.

Client's Name: _____

Client's Address: _____

Client's Phone(s): _____ Email: _____

Patient's Name(s): _____

By Signing below, I hereby authorize Seguin Animal Hospital to release my pet's medical records to (check all that apply):

Boarding and/or Grooming Facilities requesting proof of vaccinations

Veterinary clinics, hospitals, emergency hospitals, or referral centers requesting proof of vaccinations and/or medical records for treatment

Family or Friends listed below:

Client or Owner's Legal Agent Signature

Date



Seguin Animal Hospital utilizes social media marketing as a business form of marketing and as an educational resource for pet owners. Within the context of promoting the business, we would like to use images, videos, and/or information on your pet's health condition. You may or may not wish to participate as outlined below. If you do not wish to participate simply check the last box below.

I approve use of the following (initial ALL that apply):

- My pet's story
- Pictures/videos of my pet
- My pet's name (first name only)
- Pictures/videos of me
- My name (first name only)

I decline use of any web marketing (initial below):

I do NOT grant permission to use any of the above

I hereby, the undersigned, do hereby grant permission to Seguin Animal Hospital to use the above material for social media marketing. I release you, your representative, employees, managers, members, officers, parent companies, subsidiaries, and directors, from all claims and demands arising out of or in connection with any use of said "Material", including, without limitation, all claims for invasion of privacy, infringement of my right of publicity, defamation and any other personal and/or property rights.

Signature _____ Date _____
Printed name _____ Client # _____