133 South Washington State Rd.
Washington, MA 01223
Phone 413-623-5329
Fax 413-623-6609

Client and Patient Information

Thank you for giving us the opportunity to care for your pet. So that we can become better acquainted, please complete the following:

Your Full Name: ._____ Co-Owner's Name:_____

Your Address:_____ City:_____ State:_____ Zip:_____

Phone #:_____ Cell Phone #:_____ Work Phone #:_____

E-Mail Address:_____

PLEASE NOTE THAT ALL FEES ARE DUE WHEN SERVICES ARE RENDERED. We accept cash, personal checks, Care Credit and all major credit and debit cards.

How did you first learn of Hilltowns Veterinary Clinic?
Personal Recommendation (who may we thank?)_____ Hospital Sign_____
Yellow Pages_____ Internet (which site?)_____ Other_____

Patient Information	Pet #1	Pet #2	Pet #3
Name			
Species (cat, dog, etc)			
Breed			
Color			
Date of Birth or Age			
Sex (m/f) - spayed/neutered			

Who may we contact regarding your pet's vaccination history? _____

Has your pet had any serious illnesses or surgeries? _____
Does your pet have allergies to vaccinations or medications?_____
Is your pet on a special diet or medications?_____
Please indicate special concerns here:_____

I authorise Hilltowns Veterinary Clinic to examine and treat the above described pet(s). I assume responsibility for all fees incurred in the care of this pet. I also understand that these charges will be paid at the time of visit/discharge and that a deposit may be required. Should Hilltowns Veterinary Clinic need to send outstanding indebtness to collections, or enforce same through the courts, I then agree to be responsible for all fees incurred as well.

Signature:_____ Date:_____