WELCOME TO KIMBERLING ANIMAL HOSPITAL!

kimberlingvet.com • **417-739-4090**
5 Fisher Creek Dr. Kimberling City, MO 65686

CLIENT INFORMATION

First Name: ______________________ Last Name: ______________________

Second Owner First Name: ______________ Second Owner Last Name: ______________

Address: ____________________ City: __________ State: ____ Zip Code: _______

Email: (used for reminders and updates) ______________________________

Primary Phone: _____-________ Secondary Phone: _____-________

Please indicate how you would prefer your pet's health alerts delivered to you:

☐ Phone ☐ E-mail ☐ Text

How did you hear about us? _______________ Referred by? _______________

Does your pet have insurance? ☐ Yes ☐ No Insurance company: _______________

PET INFORMATION

Name: ____________________ Approximate Age: ______ Microchipped? ☐ Yes ☐ No

Please mark: ☐ Feline ☐ Canine ☐ Male ☐ Female

Spayed or Neutered? ☐ Yes ☐ No Breed: _______________ Color: __________

Current Medications/Preventives/Supplements: ______________________________

ADDITIONAL PET INFORMATION

Name: ____________________ Approximate Age: ______ Microchipped? ☐ Yes ☐ No

Please mark: ☐ Feline ☐ Canine ☐ Male ☐ Female

Spayed or Neutered? ☐ Yes ☐ No Breed: _______________ Color: __________

Current Medications/Preventives/Supplements: ______________________________

Payment is due at the time of service. We accept cash, MasterCard, Visa, Discover, American Express, CareCredit and ScratchPay.
We do not offer payment plans. A written estimate of charges can be provided prior to any services performed.

To prevent the spread of infectious disease, all hospitalized patients must be current on all vaccines and free from internal parasites.

By signing below, I confirm that I am the owner/authorized agent for the pet (s) listed on this form. I understand that I am financially responsible for any services/products provided and payment in full is due at the time services are rendered.

______________________________ ______________

Signature Date