Acct. #_____
Staff #_____

WOODBURN PET HOSPITAL
985 Evergreen Rd.
Woodburn, OR 97071
503-981-4622

info@wbpet.com

Dr. Beth Nguyen, DVM Dr. Annette Hemshorn, DVM

Thank you for giving Woodburn Pet Hospital the opportunity to care for your pet. So that we may become better acquainted, please complete the following:

Name:_____ Spouse name:_____

Address:_____

City:_____ State:_____Zip code:_____

Primary Phone:_____Work Phone:_____Spouse phone:_____

Primary Email Address:_____

Employment:_____ Position:_____

Spouse's Place of Employment_____ Position_____

So that we are able to suit your individual needs, which do you feel applies most to you:

Circle one: (1) I feel my pet is another member of our family.
(2) I feel that my pet is just a pet.
Circle one: (1) I want the best medical care available. Please recommend all that you feel is necessary
(2) I want good medical care for my pet, but must limit what I am able to have done.
Circle one: (1) I prefer to be present when my pet is examined and treated.
(2) I would rather not see my pet examined and treated.

PET INFORMATION:

Name_____ Name:_____

Breed:_____ Age:_____ Breed:_____ Age_____

Color:_____ Sex:_____ Color:_____Sex:_____

Spayed/Neutered: Yes ☐ No ☐ Spayed/Neutered: Yes ☐ No ☐

Last Vaccinations_____ Last Vaccinations_____

How did you become aware of our clinic?_____

NOTE:PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE BY CASH, DEBIT OR CREDIT CARD.
Please initial(____) IF YOUR PET REQUIRES HOSPITALIZATION OR SURGERY, A DEPOSIT WILL BE REQUIRED BEFORE SERVICES ARE RENDERED.

Please indicate preferred method of payment: ☐Cash ☐Visa/MC ☐Debit ☐Amex ☐CareCredit ☐Sunbit

STATEMENT OF ACCEPTANCE OF RESPONSIBILITY: I accept full responsibility and agree to pay all current and future expenses incurred for medical care and/or boarding at the Woodburn Pet Hospital, 985 Evergreen Rd,Woodburn, OR. My responsibility extends not only to the above listed pets, but also to any future pets I admit for treatment in the future. I understand that there may be risks involved in some of these procedures or treatments, and that no guarantees have been made as to the results and/or cure. Furthermore, if I do not pay this account as agreed, I will be responsible for 18% finance charge per year, additionly there will be a fee of $50.00 (Columbia Collections), including but not limited to attorney fees. I am 18 yrs of age or older.Please int(__)

Signature of Owner/Agent:_____ **Date:**_____