475 Verdae Blvd. Suite A
Greenville SC 29607
864.603.2290
crosswindsanimalhospital@gmail.com

CROSSWINDS
ANIMAL HOSPITAL

We appreciate you trusting us with the care of your pet(s). Please take a moment to fill out this form completely prior to your visit. All information provided is confidential.

Client Information

Owner Name: _____ SSN: _____ DL #_____
Address:_____ City: _____
State: _____ Zip Code: _____
E-mail Address: _____
Primary Phone Number: _____ Secondary Number: _____

How did you learn about our clinic? ( ) Website ( ) Referred: By whom:_____
( ) Sign ( ) Social Media
( ) Walk-In ( ) Other: _____

Patient Information

Pet's Name: _____ Species: Dog ( ) Cat ( ) Other ( ) _____
Date of Birth/Age:_____ Breed: _____
Color/Markings: _____ Sex: _____ Spayed or Neutered: ( ) Yes ( ) No

Please list ALL medications and
supplements:_____
_____
Does this pet have any prior veterinary records? ( ) Yes ( ) No
Would you like for us to contact your prior veterinarian for records? ( ) Yes ( ) No
Prior Veterinarian's name and phone number: _____

Financial Policy

Payment in full is due when services are rendered. We accept cash, check, American Express, Discover, Mastercard, Visa, Apple Pay and Care Credit. We do NOT offer payment installments. I hereby authorize the veterinarians and staff at Crosswinds Animal Hospital to examine prescribe for and/or treat the above described pet. I assume responsibility for all charges incurred in the care of the animal. I also understand that all professional fees are due at the time services are rendered.

Client Signature: _____ Date:_____