OSU VETERINARY MEDICAL HOSPITAL

Admission Record

Record #_____ Clinician_____

Owner: Name:_____ SSN or FEI #._____

Address:_____

City:_____ State:_____ Zip:_____

Phone Numbers: Home (_____)_____ Work (_____)_____

Email Address:_____ Mobile (_____)_____

How do you wish to be contacted? ◯Email ◯Phone (Please choose one)

Driver License #._____

Agent (*if other than owner*):

Name:_____ Address:_____

City:_____ State:_____ Zip:_____

Phone: Home (___)_____ Work (____)_____ Mobile (___) ____

If you are an agent for the owner, please state the agency relationship which gives you the authority to act on behalf of the owner. _____

Patient

Name_____ ◯Dog ◯Cat ◯Horse ◯Cow ◯ Other_____

Breed_____ Color(s):_____

Female ◯ Spayed ☐ Male ◯ Castrated ☐ Date of Birth:_____

Reason for Visit:_____

Name/address/phone # of your regular veterinarian: _____

_____

Were you referred to OSU by your regular veterinarian? Yes ◯ **No** ◯

Is animal insured?: Yes ◯ No ◯ Unknown ◯

If yes: Insuring Co. Name:_____ Policy No._____

Insurance Agent:_____ Phone no._____

Payment Method: (Please choose one) ◯Cash ◯Check ◯Visa ◯MasterCard ◯American Express ◯Care Credit

Release: The hospital considers your signature below to imply that you authorize release of medical record information to you or your veterinarian.

Date:_____

Signature of ◯Owner ◯Agent (Please choose one):_____

Revised 10/07/08 TMN