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# All Creatures Animal Hospital

942 Lovers Lane  
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(270) 843-9776

Thank you for choosing All Creatures Animal Hospital. It is our goal to provide your pet with the highest quality medical care they deserve. In order to serve you better, please take a minutes to fill out this short questionnaire.

Today's Date: \_\_\_\_\_

Your Name: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Place of Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

Your Pet's Name: \_\_\_\_\_ (List additional pets on the back of this form)  
Age/Date of Birth: \_\_\_\_\_ (Please circle all that applies) Male / Female Spayed / Neutered / Intact  
Dog / Cat / Other: \_\_\_\_\_ Breed: \_\_\_\_\_ Color: \_\_\_\_\_  
Place/ Date of last vaccination: \_\_\_\_\_  
Has your pet had any medical problems in the past? If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

## Financial Policy:

Our primary mission is to deliver the best and most comprehensive veterinary care available for your pet. An important part of the mission is making the cost of optimal care as easy and manageable for our clients as possible by offering several payment options. **Healthcare plans requiring comprehensive care of more than \$200.00 will require a 50% deposit to begin your pet's treatment. All Creatures requires payment in full at the end of your pet's examination and/or at the time of discharge. All Creatures charges a fee of \$25.00 for any returned checks. By signing below you agree to the foregoing terms of payment.**

## Medical Records Release:

In accordance with the Veterinary Practice Act regarding the confidentiality of patient records, "a written authorization or other form of waiver executed by the client or an appropriate court order or subpoena" is required in order for **All Creatures Animal Hospital** to produce copies of your pet's medical records. From time to time it may become necessary to retrieve or release medical record pertaining to your pet's medical history. By signing below you are allow us to both obtain medical records on your behalf and dispense them as needed to other parties.

Pet Owner's Signature: \_\_\_\_\_