

# Woodburn Pet Hospital

**Dr. Patrick L. Paradis DVM**  
**Dr. Jennifer Stoffer, DVM**

985 Evergreen Rd.  
Woodburn, Oregon 97071  
Phone: 503-981-4622  
FAX: 503-981-0908

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

Name: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 E-Mail Address \_\_\_\_\_  
 Place of Employment: \_\_\_\_\_  
 Position/Title: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's Lic. #: \_\_\_\_\_ State: \_\_\_\_\_  
 Spouse's Place of Employment: \_\_\_\_\_  
 Position/Title: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's Lic. #: \_\_\_\_\_ State: \_\_\_\_\_  
 If necessary may we call you at work?  Yes  No

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 for my pet. Please recommend all that you feel is necessary for good health.

(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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Spayed/Neutered: <input type="checkbox"/> Yes <input type="checkbox"/> No
Last Vaccinations: _____	Last Vaccinations: _____
Special Info: _____	Special Info: _____

How did you become aware of our clinic? \_\_\_\_\_

NOTE: PAYMENT IS DUE IN FULL AT THE TIME SERVICE IS RENDERED. 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  Check  Visa/M.C.

Name and Branch of your Bank: \_\_\_\_\_

**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 animals, but also to any other animals I admit for treatment in the future. Furthermore, if I do not pay this account as agreed, I will be responsible for service charges and costs of collection, including but not limited to attorney fees.

SIGNATURE of OWNER/AGENT: \_\_\_\_\_ DATE: \_\_\_\_\_