Oakdale Animal Hospital

2028 Highway 471
Brandon, MS 39047

Oakdale Animal Hospital takes pride in serving our clients and their pets. We do our best to treat your pets as we would treat our own. // We ask that you complete this form, read and sign the notice on the next page, and provide us a copy of your driver's license for identification purposes. // All clients must be 18 years of age or have someone of age complete this form prior to visit.

Owner Information:

*Name: _____ D.O.B.: _____

Driver's License: _____ (any personal information obtained is confidential & for your identity protection)

Primary Cell-Phone: _____ Address: _____

City: _____ State: _____ Zip Code: _____ E-Mail Address: _____

Place of Employment: _____ Work Phone: _____

*Spouse's Name: _____ D.O.B.: _____ Spouse's Cell-Phone: _____

Place of Employment: _____ Work Phone: _____

Please list any family members given permission to use your account other than yourself: _____ (for your protection, anyone not listed will be required to have a separate account)

*Emergency Contact (Other than Self): _____ Phone Number: _____

How Did You Find Us? (Check all that apply)

- Social Media: _____
- Personal Recommendation (Who can we thank for referring you? _____)
- Other: _____

I would like to Receive Appointment and Wellness Reminders via: (Circle all that apply)
E-Mail // Phone Call // Text Message

I give Oakdale Animal Hospital permission to use photos my pet(s) on any of their social media outlets
Yes // No

Who was your previous veterinarian? _____

Do you plan to use Oakdale Animal Hospital as your primary veterinarian?
Yes // No

I give Oakdale Animal Hospital permission to contact my previous veterinarian for medical history
Yes // No

Pet(s) Information:

*Name: _____ D.O.B. or Approximate Age: _____ Sex: _____

Breed: _____ Color: _____ Spayed/Neutered: **Yes/No**

Does your pet have a microchip? Yes/No // Who is your previous veterinarian? : _____

*Name: _____ D.O.B. or Approximate Age: _____ Sex: _____

Breed: _____ Color: _____ Spayed/Neutered: **Yes/No**

Does your pet have a microchip? Yes/No // Who is your previous veterinarian? : _____

*Name: _____ D.O.B. or Approximate Age: _____ Sex: _____

Breed: _____ Color: _____ Spayed/Neutered: **Yes/No**

Does your pet have a microchip? Yes/No // Who is your previous veterinarian? : _____

Turn Page Over →

Clinic Rules and Client Responsibilities
Please read carefully then initial each blank

_____ I understand that all patients must be current on vaccinations, including Rabies, and be free of internal and external parasites before being admitted into the clinic.

_____ I understand that a deposit may be required on any medical procedure before patients are treated.

_____ I understand that payment is due at the time services are performed and must be paid in full before a patient can be discharged from the hospital. I also understand that prices quoted before procedures are performed are just estimates and may differ from the final charges due to unforeseen circumstances.

_____ I understand that I am responsible for the bill and any other fees including but not limited to: NSF fees, monthly finance charges, court costs, attorney fees, and collection fees incurred.

_____ I understand that Oakdale Animal Hospital will use all reasonable precautions against injury, escape or death of my pet. I also authorize the use of appropriate anesthetics, and other medications, and understand that hospital personnel will be employed as deemed necessary by the veterinarian. I understand that all anesthetics involve some risk to my pet and will not hold Oakdale Animal Hospital liable or responsible in any manner or under any circumstances.

_____ I have given permission to Oakdale Animal Hospital to evaluate and treat my pet.

_____ Boarding pets must be picked up by 12pm Monday-Friday and incoming boarders cannot be dropped off before 12pm Monday-Friday. We are open on Saturdays from 8am-10am for boarding pick up and drop off ONLY. Failure to comply with these policy hours will result in a fee of $13 (per occurrence) charged to the client. Our staff is not able to discharge or accept patients into our facility outside of these hours.

_____ We understand there are times when appointments must be changed due to emergencies. However, when you do not call to cancel an appointment or boarding reservation, you may be preventing another patient from being seen and possibly getting much needed treatment. Thus, IF AN APPOINTMENT IS NOT CANCELED AT LEAST 24 HOURS IN ADVANCE, YOU WILL BE CHARGED A $30 FEE.

Signature: _____ Date: _____

Please provide a photo I.D. to the receptionist upon completion of this form.

Office use only

OAH representive :_____ Proof of identification verified: _____