



Welcome To Healing Hands Animal Hospital  
727 East Main Street  
Salisbury, Maryland 21804  
410-742-4884

*Thank you for giving us the opportunity to care for your pet(s).  
So that we may become better acquainted, please complete the following:*

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Social Security #: \_\_\_\_\_ Drivers License State/#: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address: \_\_\_\_\_

Spouse Name \_\_\_\_\_ Spouse Phone # \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Is this person authorized to make decisions on your behalf for the welfare of these pets? Yes No

**All Fees Are Due At The Time Services Are Rendered**

**We accept cash, check, Visa, MasterCard, Discover, American Express and Care Credit**

**If you were referred to us by another client whom may we thank?**

**Pet Information**

Pet Name \_\_\_\_\_ Dog \_\_\_\_\_ Cat \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Breed: \_\_\_\_\_ Color: \_\_\_\_\_ Age \_\_\_\_\_

Has your pet been spayed or neutered? \_\_\_\_\_

Has your pet had previous vaccinations? If so, where? \_\_\_\_\_

Any previous serious illnesses or surgeries: \_\_\_\_\_

**Authorization:**

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the care of the animal. I understand that these charges will be paid at the time of release and that a deposit is required for surgical treatment or hospitalization. If payment is not made as agreed, I understand that I shall be responsible for and agree to pay all reasonable collection costs including, but not limited to reasonable collection agency fees, attorney's fees and court costs.

Signature of Owner \_\_\_\_\_ Date \_\_\_\_\_