Oak Creek Veterinary Hospital
2303 Schrock Road
Columbus, Ohio 43229
614-890-9700 Fax 614-890-4341

Owners Name _____ S.S.# _____
Must be over 18 years.
Address _____
City State Zip

Home Phone _____ Cell _____

Place of Employment _____

Work Phone _____

E-mail _____ @ _____

Emergency Contact _____ Phone _____
Required Relation to You

Pets Name _____ Pets Name _____

Dog ____ Cat ____ Other _____ Dog ____ Cat____ Other _____

Male ____ Intact____ Neutered _____ Male ____ Intact ____ Neutered _____

Female ____ Intact ____ Spayed _____ Female ____ Intact _____ Spayed _____

Breed _____Color _____ Breed _____ Color _____

Age _____ Birth Date _____ Age _____Birth date _____

Reason for Visit? _____ Reason for Visit? _____

How did you hear about us? _____

Authorization for medical or surgical treatment.

- I hereby authorize the veterinarian to administer treatment as is considered therapeutically and or diagnostically necessary based on findings during the course of evaluation. I also consent to the administration of anesthetic and surgical procedures as necessary.
- I assume financial responsibility for all charges incurred to patient, and consent to the release of medical information as needed.
- I understand all returned checks are subject to a fee of $30.00.

All Unpaid Balances After 30 Days Are Subject To A $2.00 Monthly Billing Fee And 1.5% Interest Fee.

Signature _____ Date _____