OHANA Veterinary Hospital

WELCOME TO OUR OHANA!!

1414 DILLINGHAM BLVD #102-3
HONOLULU, HAWAII 96817

LISSA KAM, DVM | JENNIFER NISHIMURA, DVM | JOHN KAYA, DVM | ERIN KOPERNA, DVM | ERIN KWOCK, DVM | BETH KINOSHITA, DVM

CLIENT INFORMATION (if already a client and adding a new pet, please skip to

PRIMARY OWNER _____, _____
(last) (first)

****If you are a current client and only adding a new pet, please SKIP to Pet Information below.**

TYPE OF ID _____ ID # _____ DOB _____

SECONDARY OWNER _____, _____
(last) (first)

TYPE OF ID _____ ID # _____ DOB _____

HOME ADDRESS _____
(street no.) (zip code)

MAILING ADDRESS _____
(if different than above) (street no.) (zip code)

PHONE NUMBERS
PRIMARY OWNER (_____) _____-_____ Cell (_____) _____-_____ circle: home/work

SECONDARY OWNER (_____) _____-_____ Cell (_____) _____-_____ circle: home/work

EMAIL ADDRESS _____@_____

How did you hear about us? Referral (name)_____ Other:_____

I hereby authorize the veterinarian to examine, prescribe for, and treat the above described pet. I am responsible for all charges incurred in the care of this animal. I also understand that ***ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. WE DO NOT BILL.*** ***We accept Cash, Discover, Mastercard, Visa, JCB, Union Pay, American Express (person on card must be present)****

I grant permission for the release of any or all of the information contained in the medical record of my pet(s), listed above, to be given upon request to another veterinary practice.

After carefully reading the above, I sign in agreement.

_____ _____
Signature of owner/responsible person Date

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PET INFORMATION

PET'S NAME _____ ☐ DOG ☐ CAT ☐ OTHER: _____

☐ MALE ☐ FEMALE ☐ UNKNOWN NEUTERED / SPAYED? ☐ YES ☐ NO

BIRTHDAY/AGE _____

BREED _____ COLOR / MARKINGS _____

ALLERGIES _____

MY PET IS: ☐ TOTALLY INDOORS ☐ INDOOR / OUTDOOR ☐ OUTDOOR ONLY

Has your pet ever aggressively bitten anyone? ☐ Yes ☐ No Bitten any animal? ☐ Yes ☐ No

Is your pet okay with other animals? ☐ Yes ☐ No

Last veterinary clinic seen/Date of last vaccinations: _____(if records aren't present)