PAHOA ANIMAL HOSPITAL
15-2714 PAHOA VILLAGE RD UNIT C3
Pahoa, HI 96778
(808)930-5888

Welcome

Contact Information

Date:

Primary Owner:

Primary Phone #:

Pet Co-Owners and Relationship(s):

Secondary or Co-Owner Phone #(s):

Residental Address:

Employer:

Mailing Address:

Email Address:

Emergency Contact Name: **Phone #:**

Number of Pets: **Dogs:** **Cats:** **Other (Specify):**

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, and/or treat my pet(s). I assume full responsibility for all charges incurred for the care of my pet(s). I also understand that these charges will be paid at the time of service and that a deposit may be required for treatment.
I authorize Pahoa Animal Hospital to take photos of my pets to use in their medical record.
I acknowledge that I can request or view a copy of the Hospital Policies on the Pahoa Animal Hospital website and I agree to its terms.

Signature of Owner: **Date:**