

New Client Information

Thank you for giving us the opportunity to care for your pet. Please help us better meet your needs by taking a few moments to fill out both sides of this information sheet.

Owner's Name: _____

Spouse/Other: _____

Owner's Social Security Number: _____

Spouse/Other SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____

Work Phone #: _____

Employer's Name & Address:

If Military: Rank & Unit: _____

Spouse's/Other's Employer Name & Address:

When Is It Best to Call About Your Pet? At What Time: _____

What Phone #: _____

In Case of EMERGENCY, Call _____

At Phone # _____

We will gladly prepare a written estimate if you so desire. Please ask a receptionist or doctor. Professional fees are due at time services are rendered. If

You wish to pay by check or credit card, please complete the following.

Bank Name: _____

Driver's License #: _____

Preferred Method of Payment: Cash Check Credit Card

Veterinary Pet Insurance

(OVER)

Name of Previous/Current Veterinarian: _____

How did you hear of our hospital? _____

Individual, Someone We May Thank? _____

Yellow Pages, or another telephone directory? _____

Hospital Sign: Yes/No

Another Hospital? If so, which? _____

Other, please state:

How Would You Like To Be Reminded of Future Recommended Preventive Health Care Services For Your Pet?

Phone ()

Mail ()

Both () Phone & Mail ()

To help prevent the spread of infectious diseases, ALL hospitalized and boarded animals must be current on all vaccinations.

DUE TO STATE LAW AND INSURANCE REQUIREMENTS, ALL DOGS & CATS MUST BE CURRENT ON RABIES VACCINATION. Vaccination can be updated at the time of your appointment if it is not current.

I understand every effort will be made to achieve a successful outcome and to provide for all possible safety in hospital care and handling. I hereby authorize this hospital to receive, prescribe for, treat or perform surgery upon the pet(s) listed on the reverse side and additional pets I present. Furthermore, I agree to pay fees for services rendered at the time the pet is discharged from the hospital or the service is otherwise terminated. I agree to pay for the reasonable costs of collection in the event that collection efforts become necessary. I understand that a service fee of \$25.00 will be assessed for each non-sufficient fund check and/or certified letter that must be sent. All accounts unpaid after 30 days receive a \$5.00 Billing Charge each month and a late charge computed at a periodic rate of 1.50% per month, which is an annual percentage rate of 18.00% with a minimum monthly charge of \$1.00. If I neglect to pick up my pet within 5 days of the discharge date and do not notify you within that time period, you may assume that the pet is abandoned and are hereby authorized to dispose of the pet as you deem best and/or necessary.

Signature _____ Date _____