New Client Information

Thank you for choosing us as your pet's health care provider.

INFORMATION ABOUT YOU

Owners Name: _____ Spouse: _____
Address: _____
Street City
_____ _____
State Zip Code
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____
Do you prefer your reminders sent by email or postal mail? _____
Employer: _____ Spouses Employer: _____
Owners: Social Security Number (for check payment use only) _____
Driver's License Number:_____
In case of emergency, contact: _____ Phone Number: _____

INFORMATION ABOUT YOUR PET(S)

Pet's Name: _____ cat__ dog__ (check one)
Breed: _____ Color: _____ Sex: _____ Age: _____
Spayed or Neutered? Yes___ No ___
Date and place of last vaccinations: _____

Pet's Name: _____ cat__ dog__ (check one)
Breed: _____ Color: _____ Sex:_____ Age: _____
Spayed or Neutered? Yes___ No ___
Date and place of last vaccinations: _____

HOW DID YOU BECOME AWARE OF OUR HOSPITAL?

Hospital sign ___ Yellow Pages ___ Mail___ Web Page___ News Letter___
Individual whom we may thank_____

PAYMENT POLICY

: Professional fees are to be paid at the time services are rendered. We do not carry open accounts and hope that these alternatives are convenient to you: cash, check, Mastercard, Visa, Discover & CareCredit.

: It is our policy to provide you with a written estimate of fees for any case where in-hospital treatment, emergency care, surgery, or hospitalization will be provided. A deposit prior to treatment may be required.

: There will be a $30.00 fee added for all returned checks. There is a 1.5 % monthly service charge ($3.00 minimum) on all unpaid balances.

_____ _____ _____
Owner's Signature Print Name Date