

New Client Information

Thank you for choosing us as your pet's healthcare provider!

INFORMATION ABOUT YOU

Owner's 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: _____ Spouse's Employer: _____

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, Mastercard, Visa, Discover, American Express & 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.

Owner's Signature

Print Name

Date