New Client/Patient Form

Owner's Name: ______________________________________ Spouse's Name:________________

Address: ____ City __________________________

State ______ Zip _______ Home Phone __________________ Cell Phone_____________________

Your Employer ______________________________ Phone ___________________
May we contact you there? _______

Email Address: ____
We will NOT sell or share your email address. If you provide your email address we will be able to send you your pet's vaccination and medication reminders as well as health updates.

Do you own or have any other pets in your household? Please list: _____________________________
____

How did you hear about us?
_____ Yellow Pages _____Internet _____Saw Sign _____Former Client
_____Client *(Whom may we thank?)* ____
_____Veterinary Practice *Veterinary Practice Name* ____
_____ Other _____________________________________

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED

I understand that if I do not pay this account as agreed, the account is subject to costs of collection, attorney fees, and interest. Returned check fee is $35 per returned check. Balances over 30 days past due will be turned over to our collections agency. I understand that the hospital staff will provide an estimate of current and anticipated charges any time I request one. I am requesting that veterinary care be provided for pets presented by me or my agents. I understand that I am financially responsible for all services provided.

Type of Payment _____Cash/Check ____Credit Card ____Care Credit

Signature ____ Date ___________________

Driver's License Number* ____
(please present to receptionist to fill in)