



NEW CLIENT FORM

Thank you for giving us the opportunity to care for your pet(s). So that we may become better acquainted please complete the following:

CLIENT INFORMATION

Date: _____ Client # _____

Owner's Name: Mr./Mrs./Ms. _____
Last First Initial

Spouse's Name: Mr./Mrs./Ms. _____
Last First Initial

Address: _____ City: _____

Zip: _____ Email Address: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Method of Payment (please circle one):

Cash VISA Mastercard American Express Care Credit

ATTENTION: Personal checks are not accepted on your first visit.

ATTENTION: Your Driver's License # or a State ID# will be required. A deposit is required at the time of admission for any hospitalized service. Payment is due when services are rendered.

Drivers License or State ID #: _____

Social Security # _____ Employer: _____

HOW DID YOU HEAR ABOUT OUR CLINIC? (circle one)

Road Sign Previous Client w/ New Pet Internet News Herald Column

Personal Recommendation : _____

PATIENT INFORMATION

	PET #1	PET #2	PET #3
NAME			
BREED			
DATE OF BIRTH OR AGE			
COLOR			
SEX? SPAYED/NEUTERED?			

On occasion, we may like to post your pets' photograph and name to our website, Facebook, etc.
 Note: 18% annual interest rate is applied to all accounts 30 days past due. A \$25 bounced check fee is added for any bounced/returned checks.

I have read and agreed to all terms stated above:

Signature: _____

Date: _____