New Client & Patient Form

Date: _____

Last Name:_____ First Name:_____

Spouse First: _____ Spouse Last: _____ Salutation:_____

Street Address 1 _____ Street Address 2 _____

City, State _____ ZIP _____ Home Phone_____

Work Phone _____ Spouse Work # _____Cell Phone _____

E-mail Address _____ Occupation: _____

Employer:_____ Spouse Occ: _____ Spouse Emp:_____

Emergency Contact: _____ Em Phone# _____

Patient #1 Please Supply Vaccination Information for Each Pet

Name: _____ Species: _____ Breed: _____

Sex: _____ Spayed/Neutered? --- Birthdate: _____ Coat Color: _____

Patient #2 Please Supply Vaccination Information for Each Pet

Name: _____ Species: _____ Breed: _____

Sex: _____ Spayed/Neutered? --- Birthdate: _____ Coat Color: _____

Professional fees are to be paid at the time services are performed

In admitting my pet(s) for diagnostics, treatment, or surgery, I authorize the veterinarians of Central Animal Hospital and their support staff to administer such treatment and/or perform such diagnostic or surgical procedures as deemed necessary. It is understood that an estimate of charges will be given for services. No guarantee or assurance can be made as to the results of treatment. Further, I understand that a deposit of 50% is required before services are performed as I assume full financial responsibility for all charges incurred. I realize that these charges may exceed a given estimate if complications arise. I understand that I will be contacted prior to treatment, if possible, should complications arise.

In the event a bill is not paid, reasonable collections fees will be added in order to recover our losses.

Signature by owner or agent: _____

Signature by spouse/partner/agent: _____