



Name: _____ Spouse Name: _____

Over 65 years of age Current or Past Military Service

Mailing address: _____ City: _____ State: _____ Zip: _____

Home phone number: _____ Cell phone number: _____

Spouse phone number: _____ Spouse email: _____

Primary email address: _____

All Information collected is confidential and will not be shared without your consent.

Pet Information

	Pet 1	Pet 2	Pet 3
Name			
Species (Canine/Feline)			
Breed			
Color			
Birthday or age			
Sex(male/female/unsure)			
Spayed/Neutered/Intact			

Where can we call for previous medical records for the pets and if the account is under a different name, what is the name on the file? _____

Billing and Hospital Information

- Payment for all services must be made at the time of service or discharge.
- We accept the following forms of payment: Visa, Mastercard, American Express, Care-Credit, Cash or Check.
- Deposits are required for various visits to be booked, if the deposits are not received within 1 week of the scheduled appointment, we reserve the right to cancel your appointment.
- Please review our Hospital Policies and Payments on our website under the *About Us* tab.
- By signing below you are agreeing to treat our staff with the same respect you would expect to receive. Please always be polite and respectful to the doctors and staff. Hate speech, aggression, or belligerent behavior will result in termination of our client-patient relationship.

SIGNED: _____ Date: _____

We look forward to having you as our client.

For Hospital Use Only: Client# _____ Input Info _____ Sent T/Y _____