QUIOCCASIN VETERINARY HOSPITAL 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:

PRIMARY OWNER INFORMATION

LAST NAME: ________________________ FIRST NAME: _________________________ TITLE: ________

STREET ADDRESS: ____ APT: ________

CITY: ____________________________________ STATE: ___________ ZIP CODE: ________

HOME PHONE: __________________ CELL: __________________ WORK: __________________

EMAIL ADDRESS: ____________________________________ BEST CONTACT METHOD? _____________

OCCUPATION: _________________________________ EMPLOYER: _________________________________

SPOUSE / CO-OWNER

LAST NAME: ________________________ FIRST NAME: _________________________ TITLE: ________

HOME PHONE: __________________ CELL: __________________ WORK: __________________

BEST CONTACT METHOD? _______________ RELATIONSHIP TO OWNER: ________________________

HOW DID YOU HEAR ABOUT US? REFERRAL ___ WHO MAY WE THANK? _______________________

INTERNET _____ DROVE BY HOSPITAL _____ OTHER (please specify) _______________________

PET INFORMATION

PET #1

NAME: _________________________ SPECIES: DOG CAT

BIRTH DATE: __________________ OTHER _________________

BREED _________________________ SEX: MALE FEMALE

COLOR _________________________ SPAYED/NEUTERED: YES NO

MARKING(S) ___________________

EMERGENCY TREATMENT

IN THE EVENT OF AN EMERGENCY, DO YOU AUTHORIZE TREATMENT OF YOUR PET(S) IF EVERY ATTEMPT TO CONTACT YOU WAS UNSUCCESSFUL?

YES __ NO __ INITITAL ___

PET #2

NAME: _________________________ SPECIES: DOG CAT

BIRTH DATE: __________________ OTHER _________________

BREED _________________________ SEX: MALE FEMALE

COLOR _________________________ SPAYED/NEUTERED: YES NO

MARKING(S) ___________________

PREVIOUS VETERINARIAN

NAME: ______________________

WOULD YOU LIKE YOUR PET'S MEDICAL HISTORY TRANSFERRED TO OUR HOSPITAL?

YES __ NO ___ INITIAL ___

PREFERRED PAYMENT METHOD FOR TODAY'S VISIT: CASH ___ CHECK ___ CREDIT CARD ___

I, THE UNDERSIGNED, AND OWNER OR AUTHORIZED AGENT OF THE ABOVE MENTIONED PETS, DO HEARBY AUTHORIZE QUIOCCASIN VETERINARY HOSPITAL TO PERFORM SUCH EXAMINATIONS, DIAGNOSTIC TESTS AND TREATMENTS AS NECESSARY. I FURTHER AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL COSTS FOR SUCH PROCEDURES AND TREATMENTS. I UNDERSTAND THAT FULL PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. FAILURE TO PAY BILLS ON TIME MAY RESULT IN BILLING, FINANCE CHARGES AND/OR COSTS OF ANY COLLECTION FEE INCURRED.

SIGNATURE: ______________________________________ PRINTED NAME: ___________________________________

DATE: ____