New Client/Patient Form

Primary Owner *Financially responsible and only person authorized to make account changes, unless otherwise noted.*

First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred Contact Method: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Secondary Owner / Co-Owner

First Name: _____ Last Name: _____

Cell Phone: _____ Relation to Primary: _____

Pet Information

Name: _____ Species: _____ Breed: _____

Color: _____ Age/DOB: _____ Sex: ___Female ___Male ___Spayed/Neutered

Medical Conditions, Allergies, Relevant Comments: _____

_____

Do you have pet insurance? *Please list company:* _____

Authorization for Treatment and Payment Policy

I hereby authorize the staff of Pet Pals to render any treatment that is deemed necessary for my pet(s) health while in custody of the hospital. I understand that in the event of any unusual or emergency circumstances, the staff will make every attempt to contact me or my designated representative before, if time permits, proceeding with treatment. I understand that I will be financially responsible for all procedures including the Estimate of Charges provided to me in person or over the telephone.

I understand that professional fees are to be paid at the time services are rendered.

Signature of responsible party: _____ Date: _____

Signature of secondary owner: _____ Date: _____