WELCOME TO OUR PRACTICE

We thank you for the opportunity to provide veterinary care for your pet and family member! Please take a few moments to fill out this form as completely as possible! The receptionists will be happy to answer any questions that may arise!

CLIENT INFORMATION: **TODAY'S DATE: ___________**

Owner's Name: _______________________ Spouse/Co-Owner: _______________________

Address: _____________________________City: ______________State__________ Zip: __________

Primary Telephone: _____________________ Work Telephone: ___________________________

Cell Phone: ___________________________ Spouse/Co-Owner Phone: _______________

What is your preferred method of contact? (Phone/Text/Email) _________________

Email: ___________________________ Secondary Email: _____________________________

(strictly for in-hospital communications & reminders ONLY

Please list an Emergency Contact/anyone else authorized to seek Treatment that is not listed above:

Name_______________________ Phone Number________________________________

How did you hear about us?

Is there someone we may thank? (Client Referral) _______________________________

- **Saw our Hospital/Location**
- **Yellow Pages (Print)**
- **Online Review Site (Yelp, Angie's List ect.)**
- **Google (Or other search)**
- **Facebook/Instagram/Twitter/LinkedIn**
- **Other______________________**

****PHOTO CONSENT****

Do we have your permission to share your pet(s)' image and story on social media, our website & other forms of related media? Simply check below to authorize this:

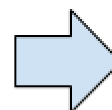
____Yes. I authorize CVVH/PTVC to share my pet's photo & story at any time.

____ No. I do not authorize this.

****TREATMENT CONSENT****

I hereby authorize the veterinarian to examine, prescribe for or treat the below-described pet(s) to the best of their abilities. I assume responsibility for all charges incurred in the care of this animal. I acknowledge that medical information will not be released to anyone not indicated on this form without my express permission.

Please Sign____



****ANIMAL MEDICAL HISTORY** *(Please complete all information for each pet)***

PET #1	PET #2
Pet's Name:	**Pet's Name:**
Date of Birth or Estimated Age:	**Date of Birth or Estimated Age:**
Species (circle one): Dog Cat Other	**Species (circle one): Dog Cat Other**
Breed:	**Breed:**
Sex:	**Sex:**
Color/Markings:	**Color/Markings:**
Vaccinations were last given by (clinic name) on:	**Vaccinations were last given by (clinic name) on:**
Allergies or Long-term Medical Problems:	**Allergies or Long-term Medical Problems:**
PET #3	**PET #4**
Pet's Name:	**Pet's Name:**
Date of Birth or Estimated Age:	**Date of Birth or Estimated Age:**
Species (circle one): Dog Cat Other	**Species (circle one): Dog Cat Other**
Breed:	**Breed:**
Sex:	**Sex:**
Color/Markings:	**Color/Markings:**
Vaccinations were last given by (clinic name) on:	**Vaccinations were last given by (clinic name) on:**
Allergies or Long-term Medical Problems:	**Allergies or Long-term Medical Problems:**

****FINANCIAL POLICY****

We accept Visa, Mastercard, Discover, American Express, Care Credit, Scratch Pay, as well as cash and checks. **Full payment is due at the time of service**. Clients with payment concerns are asked to speak to a Client Services Representative **before** their exam. Our staff is happy to provide a written treatment plan/estimate prior to services rendered. Client is responsible for a 1.5% monthly finance charge on accounts over 30 days past due and any collection fees on accounts over 90 days past due. As of Sept 1st, 2015, we offer 6 months, no interest financing via Care Credit for clients who need a credit plan. We also offer ScratchPay which acts as a personal loan for large expenses, to be paid off over time. All charges are the sole responsibility of the owner of the animal treated.

Owner's Signature: ______________________________________ Date: ___________________