

Heritage Veterinary Hospital

New Client Information

Please Print

Date: _____

Owner's Name: _____ Mr./Mrs./Ms./Dr./other: _____

Spouse/Other: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home/Main Contact Phone: _____

Cell Phone: _____ Spouse Cell Phone: _____

Other Phone number: _____ Type of number: _____

Email: _____

Driver's License # _____ Issuing State of License _____

Employer/Occupation: _____

How would you like to be reminded for appointments?

Phone# _____ **or Email** _____

What is the best time to call about your pet? _____

How did you hear about our clinic? Yellow Pages [] Hospital Web Page []

Sign [] Statue [] Internet Search [] Other _____

Whom may we thank for referring you? _____

Do you want a treatment plan with estimate for your visit? Yes _____ **No** _____



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Heritage Veterinary Hospital

New Patient Information

Please Print

Date: _____

Owner's Name: _____

Name: _____ Breed: _____ Color: _____

Date of Birth/Age: _____ Sex: _____

Where did you acquire this pet? _____

Who is primary caretaker of this pet? _____

Is your pet up to date on all vaccines? _____

Is your pet microchipped? Yes ____ No ____

Does your pet have any chronic medical conditions, if yes what? _____

Is your pet currently receiving any medications, if yes what? _____

Does your pet have any known drug allergies, if yes what? _____

Name of previous/current Veterinarian: _____

May we contact them for records? Yes ____ No ____ Phone # _____

Do you want a treatment plan with estimate for your visit? Yes ____ No ____

PAYMENT POLICY: All Fees are due and payable upon completion of services.

For your convenience we accept payment by cash, check, Care Credit, American Express, Visa, Mastercard and Discover.

Heritage Veterinary Hospital does not provide any billing services.

I understand every effort will be made to achieve a successful outcome and to provide for all possible safety in hospital care and handling. I hereby authorize this hospital to receive, prescribe for, treat or perform surgery upon the pet listed above.

Furthermore, I agree to pay for all services rendered at the time the pet is discharged from the hospital or the service is otherwise terminated. I agree to pay for reasonable costs of collection, attorney fees, and court costs in the event that collection efforts become necessary. I agree that the venue of this action will be in the county where the hospital is located. I understand that veterinary service is provided during nighttime hours as necessary in the judgment of the veterinarian in charge. Continuous presence of qualified personnel may not be provided.

Signature: _____ **Date:** _____

Hospital Employee: _____ Date: _____