

## NEW PATIENT REGISTRATION

Owner Name \_\_\_\_\_

Owner Social Security # \_\_\_\_\_ Owner DOB \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone #2 \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Spouse Name \_\_\_\_\_

Spouse Social Security # \_\_\_\_\_ Spouse DOB \_\_\_\_\_

Spouse Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

**PET INFORMATION**

Pet's Name \_\_\_\_\_ Breed \_\_\_\_\_

Pets Age/DOB \_\_\_\_\_ **Circle:** Dog/Cat/Other Male/Female Neutered/Spayed

Pet's Name \_\_\_\_\_ Breed \_\_\_\_\_

Pets Age/DOB \_\_\_\_\_ **Circle:** Dog/Cat/Other Male/Female Neutered/Spayed

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Pets Age/DOB \_\_\_\_\_ **Circle:** Dog/Cat/Other Male/Female Neutered/Spayed

**All payments are due at the time of services rendered.** I understand that I will be legally responsible for all emergency procedures including the estimate of charges provided to me in person or over the telephone. I understand that a deposit may be required on all pets admitted to the hospital. In addition to any outstanding amount, a late fee of 1% monthly on all unpaid balances, plus cost of collections, including reasonable attorney fees, court costs, and collections fees, may incur in recovering the amount owed.

We accept cash, checks, all major credit cards as well as Care Credit, which can be approved in as little as 10 minutes.

I have read and understand the above statement.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_