

## New Client / Patient Form

Welcome to Pharr Road Animal Hospital. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you. We look forward to working with you in maintaining your pet's health.

**OWNER INFORMATION:** Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Address: \_\_\_\_\_ County (check one):  Fulton  DeKalb  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  Other county \_\_\_\_\_  
Primary phone: \_\_\_\_\_ This is a...  Cell  Home  Work  
Secondary phone: \_\_\_\_\_ This is a...  Cell  Home  Work  
Email address: \_\_\_\_\_

### **Additional person to add to your account, if applicable:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Relationship (check one):  Spouse  Significant other  Co-owner  Relative  Friend  Other

**How did you find out about Pharr Road Animal Hospital?** (select one)  Ahimsa House  Community Event   
 Emergency Clinic  Employee (non-DVM)  Facebook  Google  Other Web Search  Sign/Drove By   
 Veterinary Specialist  Word of Mouth  Yellow Pages  Yelp

Specific person -- Please tell us who we can thank: \_\_\_\_\_

**We love social media!** We may wish to share your pet's image and story on social media, our website, and other forms of related media and educational materials. Your full name and personal information will never be shared.

### **Choose one:**

Yes, I authorize Pharr Road Animal Hospital to share my pet's photo and story at any time.

*No, I do not consent to have my pet's image and/or story shared.*

**TREATMENT CONSENT:** By completing this form, you authorize the veterinarian(s) to examine, diagnose, and treat the below-described pet(s) to the best of their abilities. All in-patients must be current on vaccines and free from parasites. To comply with this policy, certain treatments may be necessary to protect the health and safety of all pets in our care. You assume responsibility for all charges incurred in the care of your pet(s).

**FINANCIAL POLICY:** We accept Visa, Mastercard, Discover and American Express, cash and checks. Full payment is due at the time of service. Clients with payment concerns are asked to speak to a staff member before the exam. We are happy to provide you with a written treatment plan prior to services being rendered. No payment plans are offered.

***Your signature below indicates your agreement with hospital policies and all other information listed above.***

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

Driver's License Number # \_\_\_\_\_ DOB: \_\_\_\_\_

**PET INFORMATION ON NEXT PAGE**

# **New Client / Patient Form**

## **PET INFORMATION:**

Pet Name: \_\_\_\_\_ Species (check one):  CANINE  FELINE

Breed: \_\_\_\_\_ Date of birth or approximate age: \_\_\_\_\_

Sex:  Neutered male  Spayed female  Male (intact)  Female (intact)

Color: \_\_\_\_\_ Microchip # (if present/known): \_\_\_\_\_

Allergies and/or medical problems: \_\_\_\_\_

Previous Veterinary Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_

*\*Please provide records from your previous veterinarian*

## **SECOND PET INFORMATION:**

Pet Name: \_\_\_\_\_ Species (check one):  CANINE  FELINE

Breed: \_\_\_\_\_ Date of birth or approximate age: \_\_\_\_\_

Sex:  Neutered male  Spayed female  Male (intact)  Female (intact)

Color: \_\_\_\_\_ Microchip # (if present/known): \_\_\_\_\_

Allergies and/or medical problems: \_\_\_\_\_

Previous Veterinary Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_

*\*Please provide records from your previous veterinarian*

## **THIRD PET INFORMATION:**

Pet Name: \_\_\_\_\_ Species (check one):  CANINE  FELINE

Breed: \_\_\_\_\_ Date of birth or approximate age: \_\_\_\_\_

Sex:  Neutered male  Spayed female  Male (intact)  Female (intact)

Color: \_\_\_\_\_ Microchip # (if present/known): \_\_\_\_\_

Allergies and/or medical problems: \_\_\_\_\_

Previous Veterinary Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_

*\*Please provide records from your previous veterinarian*