



# EAST PADDEN ANIMAL HOSPITAL

## Client Contact Form

Name: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ DOB \_\_\_\_\_

Employer \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Driver License Number \_\_\_\_\_

Email \_\_\_\_\_

*(We will not share your email and will use it to send you information regarding your pets and/or account only).*

How did you become aware of our clinic? \_\_\_\_\_

Whom can we thank for referring you? \_\_\_\_\_

May we take a photo of your pet(s) for our records? (please circle) Yes No

May we share your pet's photo(s) on our website and/or social media pages? Yes No

Patient Info	Pet #1	Pet #2	Pet #3	Pet #4
Name				
Breed				
Birthdate				
Color(s)				
Sex	Male/Female	Male/Female	Male/Female	Male/Female
Spayed or Neutered?	Yes/No	Yes/No	Yes/No	Yes/No
Previous Vet				
Do you authorize us to obtain previous records?	Yes/No	Yes/No	Yes/No	Yes/No

**Payment in full is required at the time services are rendered. Please circle your form(s) of payment:**

Cash    Visa    MasterCard    Debit/ATM    CareCredit

*We are unable to accept checks.*

### Release and Authorization

*I hereby authorize the veterinarian to examine, prescribe for, or treat my pet(s). I assume financial responsibility for all charges incurred. I understand that I will be given an explanation of necessary procedures and an estimate of costs prior to incurring any expense greater than \$150.00 total, unless I request otherwise. I also understand that all charges must be paid in full at the time of discharge.*

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