

ANIMAL HOSPITAL OF NEW PORT RICHEY

CLIENT INFORMATION:

DATE _____

Name _____ Spouse's name _____

Address _____ City _____ State _____ Zip _____

May we text to your cell phone number (appointments, procedure release, etc.)? ____Yes ____No

Primary contact Cell phone (____)_____ Name of contact for this number_____

Secondary contact Cell phone (____)_____ Name of contact for this number_____

Home phone number (____)_____

May we communicate with you through your email (reminders, promotions, etc.)? ____Yes ____No

Email:_____

Place of employment_____ Work contact number (____)_____

Was there a Personal recommendation on how you become aware of our clinic? (whom may we thank?)

PATIENT INFORMATION:

Name	
Species (Please circle)	Cat Dog
Breed	
Date of birth or Approximate age	
Color	
Sex (Please circle)	Male Female
Spayed/neutered? (Please circle)	Yes No
Is there a history of allergies to any of the following: Vaccines/Medication//Environmental/Food? If yes, please list:	

FINANCIAL POLICY:

Payment Options:

Cash, Check(established clients only), Visa®, MasterCard®, American Express®, Discover Card® or CareCredit®

Animal Hospital of New Port Richey charges vary for returned checks.

We do not accept checks from new clients.

Deposit & Billing:

For some treatments or hospitalized care, a deposit or payment in full may be required to begin your pet's comprehensive care. If you have an account 60 days past due, Animal Hospital of New Port Richey may relinquish your balance owed to a collection agency.

By signing, I attest the information provided is accurate and understand the terms of the financial policy.

Owner or Responsible Party Signature:_____