Christensen Animal Hospital™

Caring People, Caring for Pets

New Client Information

Name _____ Primary contact # _____ ◯ Home ◯ Work ◯ Cell

Spouse _____ Primary contact # _____ ◯ Home ◯ Work ◯ Cell

Addt'l contact # _____ ◯ Home ◯ Work ◯ Cell

Emergency Contact _____ Contact # _____ ◯ Home ◯ Work ◯ Cell

Address _____ City _____ St _____ Zip _____

Email Address (for Dr. Communication, news & specials) _____

How did you hear about us? _____ May we thank someone for the referral? _____

Patient Information

Pet is a ◯ Dog ◯ Cat ◯ Other _____

Pet's Name _____ Breed _____ Color _____

Age/Birthday _____ Sex: ◯ Male ◯ Female Altered ◯ Yes ◯ No Allergies _____

Vaccine Reactions _____ Medications _____

Is your pet current on their vaccinations? ◯ Yes ◯ No Did you bring a copy of your pets medical history ◯ Yes ◯ No

If not, which hospital may we call? _____ Phone # _____

**I hear by authorize previous veterinary clinics and veterinarians to release the medical records of my pets.*

Owner/Authorized Agent Signature _____ Date _____

FINANCIAL POLICIES:

- ALL FEES ARE DUE AND PAYABLE UPON RELEASE OF YOUR PET.
- We will gladly prepare a written estimate if you so desire. Please ask the receptionist or doctor.
- If you prefer paying by check, please provide your: DL#: _____
- A deposit may be required for hospitalized medical or surgical cases.
- Please note there is a $35.00 service charge on all checks that are returned for non-sufficient funds. Any unpaid Balance will accrue a finance charge at a rate of **1.75% monthly, with a minimum finance charge of $5.00**.

I assume financial responsibility for all charges incurred to the patient. I have read and understand the above financial policies. I further understand that if I do not pay the entire amount, I will be responsible for any and all fees incurred in collecting unpaid balances including but not limited to attorney fees, court costs, and collection agency fees, etc.

_____

Owner/Authorized Agent Signature Date