Welcome To Estero Animal Hospital

9550 Corkscrew Road * Estero, Florida 33928 * (239) 992-3883

Date:_____

Thank you for giving us the opportunity to care for your pet(s). So that we may become better acquainted, please complete the following:

CLIENT INFORMATION

Title: (circle one) Mr. Mrs. Miss. Ms. Dr

First Name: _____ Last Name: _____

Address: _____ Driver's License # _____

_____ SSN: _____

City: _____ State:_____ Zip:_____

Phone: _____ ☐ Cell, ☐Work, ☐Home Alternate: _____☐ Cell, ☐Work, ☐Home

E-Mail Address: _____ (This is for reminders and hospital communication only)

Significant Other Name: _____ Phone: _____☐ Cell, ☐Work, ☐Home

PATIENT INFORMATION

	PET #1	PET #2	PET #3
NAME			
BREED			
DATE OF BIRTH			
COLOR/MARKINGS			
SEX; SPAYED OR NEUTERED?			

Please list your previous vet(s) and contact number so we may contact them for records:

_____

_____

_____

HOW DID YOU BECOME AWARE OF OUR CLINIC?

☐ Drove by ☐ Online Search ☐ Other (please explain): _____

HOW WILL YOU BE PAYING FOR YOUR SERVICES?

☐ Cash ☐Check ☐ Visa ☐ MasterCard ☐ Discover ☐ Am. Express ☐ CareCredit

FINANCIAL AGREEMENT:

I, _____, understand that the full balance my account is due at the time services are received. If my account is sent to collections, I understand a collection fee of 30% of the outstanding balance will be added to my account and shall become part of the total amount due. I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. I also understand that if my account is submitted to a collection agency I will no longer be allowed to obtain veterinary services at the Estero Animal Hospital for all current and future animals.

Signature of responsible party: _____ Date: _____

Hospital Use Only:

Copied Driver's License ☐ Signed Financial Agreement ☐ Called For Records ☐ Entered Vaccine History ☐