New Client Form

Owner's Name___________________________________ Co Owner's name_________________________

Address:____

City:____________________________________State:________________________Zip:_________________

Home Phone (_______) ________-___________ Cell Phone (_______)_________-_____________

Place of Employment:______________________________________ Phone (_______) ______-_________

Co Owner Place of Employment:_____________________________ Phone (_______) ______-_________

E-Mail Address:____

How did you hear about us?____

Do any of your pets have a history of vaccine reactions?____

Driver's License # _______________________________ State______ (required if paying by check)

I grant permission for Southside Animal Hospital to use my pets' photo(s) on Facebook. _______ (initial)

Pet's name	Species	Breed	Color	Birthdate	Sex (fixed?)

I authorize Southside Animal Hospital to perform services, diagnostic procedures, and treatment as deemed necessary for proper veterinary care. I/We authorize release of any information concerning my pets' health to other parties working with or in treatment of above mentioned animals. I accept full financial responsibility for any services rendered and understand that payment is due at time of services. Should I not pay the balance in full, I agree to pay all expenses incurred to collect the debt including but not limited to: attorney fees, collection costs, rebilling fees, and any additional fees incurred by your pet while in our care. There will be a minimum returned check fee of $25.00. All returned checks will be turned over to the Solicitor for collection if not paid in full within 10 days of bank rejection date.

Signature:____ Date:_________________________

- Entered
- Scanned
- NCC