

PATIENT / CLIENT INFORMATION

Goodwin Animal Hospital

**4701 Atlanta Hwy Mont., AL 36109 / 11485 Chantilly pkwy. Pike Road, AL 36064
334-279-7456 / 334-279-0500**

Thank you for giving us the opportunity to care for your pet. Please help us meet your needs better by taking a moment to complete each page.

Date _____.

Owner's Name _____ Spouse/Other _____.

Address _____ City _____ State _____ Zip _____.

Home Phone _____ Work Phone _____ Cell Phone _____.

To establish an account you must be a legal adult 19 or older: DOB: _____.

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE:

I, the undersigned, give Goodwin Animal Hospital, its employees and/or agents "express prior consent" to contact me at any/all phone numbers, including cell phone numbers (by phone call or text message), for the purpose of treatment, insurance and/or payment.

Employer's Name & Address _____.

Spouse's/Other's Employer & Address _____.

E-mail address: _____.

In case of EMERGENCY, please call _____ at telephone number _____.

Social Security # _____ Spouse Social Security # _____.

Driver's License # _____ Spouse Driver's License # _____.

FOR IDENTITY THEFT PURPOSES WE NEED TO SEE A COPY OF A VALID PHOTO ID. WE WANT TO TRY AND HELP STOP IDENTITY THEFT BY MAKING SURE THE PERSON WHO SIGNS AND AUTHORIZES SERVICES WITH US IS IN FACT THE ONE WHO SIGNS THIS PAPERWORK.

If you have any additional person(s) that you will allow to bring in, pick up or make any medical decisions for your pet(s) in your behalf please list them below with a contact number.

If you have anyone that is NOT authorized to pick up and/or make any medical decisions regarding your pet(s) please list them below.

OUR ACCOUNTING SYSTEM IS NOT SET UP TO INVOICE OUR CLIENTS. PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. BY SIGNING BELOW, I AM STATING THE ABOVE INFORMATION IS TRUTHFUL AND CORRECT. SHOULD IT BECOME NECESSARY TO FORWARD THE ACCOUNT FOR COLLECTION, I AGREE TO BE RESPONSIBLE FOR ANY/ALL COLLECTION COSTS, SERVICE FEES, ATTORNEY FEES, AND/OR COURT COSTS WHICH WILL INCLUDE A 33.33% COLLECTION FEE. I WAIVE NOW AND FOREVER MY RIGHT OF EXEMPTION UNDER THE LAWS OF THE CONSTITUTION OF THE STATE OF ALABAMA AND ANY OTHER STATE.

Any unpaid balance will be subject to a service charge of 1.5% per month, (18% APR). Late charges and additional service charges may also be added under certain conditions.

How did you first hear of our hospital?

Friend or Relative: Name: _____

Yellow Pages:

Web Search Page:

Groomer:

Used to be client more than 5 years ago:

Outside Sign:

Location:

Our Web Page:

Boarding:

Other: _____

TO PREVENT THE SPREAD OF INFECTIOUS DISEASES AND PARASITES, HOSPITALIZED AND BOARDING ANIMALS MUST BE CURRENT ON ALL VACCINES AND FREE OF INTERNAL AND EXTERNAL PARASITES. I AUTHORIZE THE DOCTOR TO PROVIDE VACCINES AND PARASITE CONTROL AS NEEDED FOR MY PET.

We will gladly prepare a written estimate if you desire. Please ask the receptionist or doctor.

COMMENTS:

Signature of Owner

Secondary Signature

Date

Date

ANIMAL MEDICAL HISTORY

(Please complete all information for each pet)

Pet Origin: Humane Society Pet Shop Kennel Advertisement
 Friend Stray Individual (nonbreeder)

	Pet # 1	Pet #2	Pet #3
Pet's Name			
Species (cat, dog, other)			
Breed			
Description (color)			
Date of Birth			
Age (years)			
Sex			
Length of time owned			
Neutered/Spayed			
Vitamins			
Diet (kind of pet food)			
Type of Grooming Products			
VACCINATIONS			
Name of Former Clinic			
Date of DHPP (distemper/parvo)			
Date of Bordetella (dog)			
Date of K-9 Influenza			
Date of Rabies (dog./cat)			
Date of Heartworm Test			
Name of Heartworm Preventative			
Date of FVRCP (infectious disease-cat)			
Date of Feline Leukemia			
Date of Feline Bordetella			
Date of Fecal Exam (worms dog/cat)			
Other Vaccinations			
Prior Illness			
Prior Surgery(s)			
Dentistry			