

New Client / Patient Form

Welcome to Inman Park Animal Hospital. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you. We look forward to working with you in maintaining your pet's health.

OWNER INFORMATION:

Dr. Mr. Mrs. Ms.

Last Name: _____ First Name: _____

Address: _____ County (check one): Fulton DeKalb

City: _____ State: _____ Zip: _____ Other county _____

Primary phone: _____ This is a... Cell Home Work

Secondary phone: _____ This is a... Cell Home Work

Email address: _____

Additional person to add to your account, if applicable:

Last Name: _____ First Name: _____ Cell phone: _____

Relationship (check one): Spouse Significant other Co-owner Relative Friend Other

How did you find out about Inman Park Animal Hospital? (select one) Ahimsa House Community Event

Dr. Ellard Dr. Fowler Dr. Kumar Emergency Clinic Employee (non-DVM) Facebook Google

Other Web Search Sign/Drove By Veterinary Specialist Word of Mouth Yellow Pages Yelp

Specific person (Please tell us who we can thank!) _____

We love social media! We may wish to share your pet's image and story on social media, our website, and other forms of related media and educational materials. Your full name and personal information will never be shared. **Choose one:**

Yes, I authorize Inman Park Animal Hospital to share my pet's photo and story at any time.

No, I do not consent to have my pet's image and/or story shared.

TREATMENT CONSENT: By completing this form, you authorize the veterinarian(s) to examine, diagnose, and treat the below-described pet(s) to the best of their abilities. All in-patients must be current on vaccines and free from parasites. To comply with this policy, certain treatments may be necessary to protect the health and safety of all pets in our care. You assume responsibility for all charges incurred in the care of your pet(s).

FINANCIAL POLICY: We accept Visa, Mastercard, Discover and American Express, cash and checks. Full payment is due at the time of service. Clients with payment concerns are asked to speak to a staff member before the exam. We are happy to provide you with a written treatment plan prior to services being rendered. No payment plans are offered.

Your signature below indicates your agreement with hospital policies and all other information listed above.

Signature: _____ Date: _____

TURN PAGE TO COMPLETE PET INFORMATION

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PET INFORMATION:

Pet Name: _____ Species (check one): CANINE FELINE

Breed: _____ Date of birth or approximate age: _____

Sex: Neutered male Spayed female Male (intact) Female (intact)

Color: _____ Microchip # (if present/known): _____

Allergies and/or medical problems: _____

Vaccine and test history dates (complete to the best of your knowledge):

DOGS:

Rabies _____
DA2PP _____
Lepto _____
Bordetella _____
Canine Influenza _____
Heartworm test _____ negative positive
Fecal exam _____ negative positive
Other _____

CATS:

Rabies _____
FVRCP _____
FELV _____
FIV/FelV test _____ negative positive
Fecal exam _____ negative positive
Other _____

Previous Veterinary Practice Name: _____ Phone: _____

SECOND PET INFORMATION:

Pet Name: _____ Species (check one): CANINE FELINE

Breed: _____ Date of birth or approximate age: _____

Sex: Neutered male Spayed female Male (intact) Female (intact)

Color: _____ Microchip # (if present/known): _____

Allergies and/or medical problems: _____

Vaccine and test history dates (complete to the best of your knowledge):

DOGS:

Rabies _____
DA2PP _____
Lepto _____
Bordetella _____
Canine Influenza _____
Heartworm test _____ negative positive
Fecal exam _____ negative positive
Other _____

CATS:

Rabies _____
FVRCP _____
FELV _____
FIV/FelV test _____ negative positive
Fecal exam _____ negative positive
Other _____

Previous Veterinary Practice Name: _____ Phone: _____