Embassy Lakes
Animal Hospital

Welcome To Our Clinic!

Payment Policy: full payment is required at the time of your visit. We accept cash, VISA, Mastercard, Discover, American Express, personal checks with Driver's License, and CareCredit.

RESPONSIBLE PARTY INFORMATION:

Name:_____ Phone No:_____

Spouse Name:_____ Alt. Phone No:_____

Address:_____ City:_____ Zip:_____

Email Address:_____ Driver's License No._____

Employer:_____

Emergency Phone Numbers:_____

NEW CLIENTS: How did you hear about our practice? Please circle one:

- Google - Website - Facebook - Yelp - Other _____
- Yahoo - Twitter - Angie's List - Friend/Family:_____ _____

PATIENT(S) INFORMATION:

1st Pet

Name of Pet:_____ Species:_____ Breed:_____ Color:_____

Date of Birth (if known):_____ Age:_____ Sex:_____ Spayed or Neutered:_____

Does your pet have microchip?_____ What kind of food do you feed your pet?_____

2nd Pet

Name of Pet:_____ Species:_____ Breed:_____ Color:_____

Date of Birth (if known):_____ Age:_____ Sex:_____ Spayed or Neutered:_____

Does your pet have microchip?_____ What kind of food do you feed your pet?_____

Please check any symptoms or problems that you have noticed about your pet(s):

Patient Number 1			Patient Number 2		
☐ Arthritis	☐ Excessive Chewing	☐ Scratching	☐ Arthritis	☐ Excessive Chewing	☐ Scratching
☐ Bad Breath	☐ Eye Bulging or Bloodshoot	☐ Seems Depressed	☐ Bad Breath	☐ Eye Bulging or Bloodshoot	☐ Seems Depressed
☐ Behavior Problems	☐ Gagging	☐ Shaking Head	☐ Behavior Problems	☐ Gagging	☐ Shaking Head
☐ Bleeding Gums	☐ Lack of Appetite	☐ Sneezing	☐ Bleeding Gums	☐ Lack of Appetite	☐ Sneezing
☐ Blood in Urine/Stool	☐ Limping	☐ Thirst and/or Urination Increased	☐ Blood in Urine/Stool	☐ Limping	☐ Thirst and/or Urination Increased
☐ Breathing Problems	☐ Loss of Balance	☐ Vomiting	☐ Breathing Problems	☐ Loss of Balance	☐ Vomiting
☐ Changes in Environment	☐ Mass or Lump	☐ Weakness	☐ Changes in Environment	☐ Mass or Lump	☐ Weakness
☐ Coughing	☐ Potty Training Issues	☐ Weight Problems	☐ Coughing	☐ Potty Training Issues	☐ Weight Problems
☐ Diarrhea/ Constipation	☐ Scooting	☐ Other_____ _____	☐ Diarrhea/ Constipation	☐ Scooting	☐ Other_____ _____

The undersigned agrees, whether he or she signs as agent or owner, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself or herself to pay for the account of the hospital in full at the time services are rendered. Should the account be referred to an attorney or collection agency for collection, the undersigned agrees to pay all attorney's fees and collection expenses. All delinquent accounts shall accrue interest at the rate of 15% per month (18%APY).

_____ _____

Signature of Owner or Agent Witness