NEW CLIENT FORM

Client # _____ (Office use only)

WE KNOW YOUR PET'S HEALTH IS IMPORTANT AND WE THANK YOU FOR TRUSTING US TO CARE FOR THEM. TO HELP US PROVIDE THE BEST CARE POSSIBLE, PLEASE TAKE A FEW MOMENTS TO FILL OUT THIS FORM COMPLETELY. THANK YOU!

NAME*

First name

Last name

DRIVER'S LICENSE #/STATE*

DL#

STATE

CELL PHONE NUMBER*

(000) 000 - 0000

EMAIL ADDRESS*

☐ Check here if you'd like email reminders

MAILING ADDRESS*

Street address

Street address Line 2

City

State

Zip Code

SPOUSE/SECOND OWNER

First name

Last name

SPOUSE PHONE NUMBER

(000) 000 - 0000

HOW DID YOU HEAR ABOUT OUR CLINIC?

— PET HEALTH HISTORY —

NAME OF PET*

TYPE OF PET*

- ⬜ DOG
- ⬜ CAT
- ⬜ EXOTIC, SMALL MAMMAL
- ⬜ EXOTIC, REPTILE/AMPHIBIAN
- ⬜ EXOTIC, AVIAN
- ⬜ OTHER:

SEX*

- ⬜ MALE NEUTERED
- ⬜ MALE INTACT
- ⬜ FEMALE SPAYED
- ⬜ FEMALE INTACT

BREED*

COLOR*

BIRTHDATE OR AGE*

MM/DD/YYYY or YEARS

REASON FOR VISIT*

- ⬜ Wellness/No concerns
- ⬜ Wellness and concerns
- ⬜ Sick visit/concerns
- ⬜ Second opinion
- ⬜ OTHER:

WHERE CAN WE CALL TO GET PREVIOUS MEDICAL HISTORY?*

**Please include the hospital name and phone number!

FOR ADDITIONAL PETS: PUT NAME, SEX, BREED, COLOR AND AGE

DO YOU HAVE PET INSURANCE?*

⬜ YES ⬜ NO

If yes, specify the name of the insurance and which pets are covered:

SOCIAL MEDIA CONSENT*

I hereby grant Carolina Beach Animal Hospital and their staff permission to use my pet's name, biography, photograph, or performing persona for marketing, educational materials, print, broadcast, or distribution in any format or media known now or in the future. I understand that this consent is effective until such time as I revoke it in writing and provide a copy of the revocation to Carolina Beach Animal Hospital.

⬜ YES ⬜ NO

AUTHORIZATION*

☐ **I HEREBY AUTHORIZE THE VETERINARIAN TO EXAMINE, PRESCRIBE FOR, AND/OR TREAT MY PETS I ASSUME FULL RESPONSIBILITY FOR ALL CHARGES INCURRED FOR THE CARE OF ALL MY PETS ON MY FILE. I ALSO UNDERSTAND THAT THESE CHARGES WILL BE PAID AT THE TIME OF RELEASE AND THAT A DEPOSIT MAY BE REQUIRED FOR SURGICAL TREATMENT OR HOSPITALIZATION. I ALSO UNDERSTAND AND AGREE TO RESPONSIBILITY FOR ANY COLLECTION/FINANCE CHARGES FOR A BALANCE DUE FOR ANY REASON.**

SIGNATURE*

DATE OF SIGNATURE*

MM/DD/YYYY

METHOD OF PAYMENT*

☐ VISA ☐ DISCOVER ☐ CARECREDIT ☐ OTHER:

☐ AMEX ☐ MASTERCARD ☐ CASH