

# Welcome to Bethany Animal Hospital -- New Client/Pet Information Form

Owner's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Client #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ OR I.D./Drivers License: \_\_\_\_\_

Name of who *referred* you to Bethany Animal Hospital? \_\_\_\_\_

Spouse/Partner name: \_\_\_\_\_ Work phone #:(\_\_\_\_) \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ SSN#: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Relation to you: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_

Pet Insurance?  No  Yes If yes, insurance company name: \_\_\_\_\_

**Pet Information: (if you have more than 1 pet please fill out separate forms)**

Name: \_\_\_\_\_  Dog 🐕  Cat 🐈 **Microchip:**  No  Yes

Breed(s): \_\_\_\_\_ Color/Markings: \_\_\_\_\_ Age: \_\_\_\_\_ yrs/mos

Sex (select one):  Spayed Female  Neutered Male  Male  Female

Please give **month, and year & veterinarian** that these vaccinations/tests were performed:

**DOGS 🐕**

**CATS 🐈**

<b>Rabies Vaccination</b>		<b>Feline Leukemia Test</b>	
Distemper-H-P-Parvo		<b>Rabies Vaccination</b>	
Corona		Feline Distemper Combo (FVRCP)	
Bordatella		Feline Leukemia Vaccination	
Heartworm Test		Fecal Exam	
Fecal Exam		Dental Exam	
Dental Exam		Indoors only <input type="checkbox"/> / Outside cat <input type="checkbox"/>	In & Out doors <input type="checkbox"/>

Previous medical/surgical history: \_\_\_\_\_

Is your pet currently on any medication?  Yes  No If Yes, Please list: \_\_\_\_\_

Any known allergies? \_\_\_\_\_

**Bethany Animal Hospital does not extend credit nor do we do any billing. Payment is expected for services at the time services are rendered. We accept CASH, ATM –Debit, Visa, Master Card, Discover and Care Credit. No CHECKS accepted. No PAYMENT PLANS.**

Financial responsibility: I agree to pay all finance charges, collection costs, attorney fees, and any other costs that may be incurred to enforce collection of any amount outstanding. All account balances over 30 days old will be subject to 3% interest and a \$5.00 monthly billing fee.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_