

Animal Hospital of Laveen

Client Information Form

First Name:		Last Name:		
Street Address:				
City:			State:	ZIP:
Home Phone:		Work Phone:		Cell Phone:
E-mail:			Additional Owner(s):	
How did you hear about us? <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Walk-In <input type="checkbox"/> Friend _____ <input type="checkbox"/> Other (please specify): _____				
TREATMENT AUTHORIZATION and INFORMATION/PHOTO RELEASE				
I hereby authorize the veterinarians & staff at the Animal Hospital of Laveen to perform medical, diagnostic and/or surgical procedures on my pet as required for diagnosis and treatment. I understand that I can terminate treatment at any time by contacting the doctors or assistants.				
I consent to the release of medical information				
FINANCIAL POLICY				
Payment is due at the time services are rendered. For hospitalized cases, a deposit is required at the time of patient check-in; the balance is due upon discharge from the hospital. We accept cash, or credit cards (Visa, Care Credit, MasterCard, Discover or debit cards). In order to avoid misunderstandings, please let us know immediately if these terms are not satisfactory.				
In the event payment is not made at the time of service, it is our policy to apply a service charge to accounts with a balance over <u>30</u> days old. Past due accounts shall pay interest at the maximum legal rate. I agree to pay all attorneys' fees, interest, collection costs and other costs of litigation incurred in the collection of past due accounts.				
All returned checks will incur a charge.				

PET INFORMATION

Pet's Name:	Species: <input type="checkbox"/> Canine <input type="checkbox"/> Feline Other:	Age or Date of Birth:
Breed/Sex	Color/Markings:	Spayed <input type="checkbox"/> Neutered <input type="checkbox"/>
Vaccine History	Fecal/Heartworm Testing	Medical Conditions and Current Medication:
Pet's Name:	Species: <input type="checkbox"/> Canine <input type="checkbox"/> Feline Other:	Age or Date of Birth:
Breed/Sex	Color/Markings:	Spayed <input type="checkbox"/> Neutered <input type="checkbox"/>
Vaccine History	Fecal/Heartworm Testing	Medical Conditions and Current Medication:
Pet's Name:	Species: <input type="checkbox"/> Canine <input type="checkbox"/> Feline Other:	Age or Date of Birth:
Breed/Sex	Color/Markings:	Spayed <input type="checkbox"/> Neutered <input type="checkbox"/>
Vaccine History	Fecal/Heartworm Testing	Medical Conditions and Current Medication:

Please provide a contact in case of an emergency:

Name(s):

I have read and agree to the treatment authorization, medical release and financial obligations.

Signature:

Date: