

New Client Information

Name: _____
First Last Pronouns

Address: _____
Street City, State, Zip Code

Primary Phone # _____ Type: _____ Secondary Phone # _____ Type: _____

Email address _____

Alternate Contact: _____
Name Phone Relationship

Pet Insurance: YES NO Insurance Company: _____ Policy #: _____

New Pet Information

Name of previous Veterinary Clinic, if applicable: _____

Pet Name: _____

Pet Name: _____

Female / Spayed Female Male / Neutered Male

Female / Spayed Female Male / Neutered Male

Birth Date: _____ Cat / Dog

Birth Date: _____ Cat / Dog

Breed: _____

Breed: _____

Color: _____

Color: _____

- In admitting my pet(s) for examination, diagnostics, treatment, or surgery, I authorize the veterinarians of Hillside Veterinary Hospital, and their support staff, to administer such treatment and/or perform such diagnostic or surgical procedures as deemed necessary.
- I understand that I assume full financial responsibility for all charges incurred by my pet. I realize that these charges may exceed a given estimate if complications arise. I understand that I will be contacted prior to treatment, if possible, should complications occur.
- As our client, you agree to pay for any collection or legal costs incurred in the collection of any debt. In order to reinstate your account all balances will need to be paid in full.

PROFESSIONAL FEES ARE TO BE PAID AT THE TIME SERVICES ARE PERFORMED.

Signature: _____

Date: _____