

## 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: \_\_\_\_\_