Where pets take their people

HILL TOP
Animal Hospital

NEW PATIENT FORM

Client Information

Name of Owner ______________________________

Address ______________________________

City ____________ State ____________ Zip ____________

Home Phone ____________ Work Phone ____________ Cell ____________

Email Address ______________________________

Name and Number of Other Authorized Responsible Party (Spouse, Parent) ____________

Have you visited Hill Top Animal Hospital before with another pet? ☐ Yes ☐ No

(Bonus Question) How did you hear about us? ______________________________

Patient Information

Name ______________________________

Birth date/Age ____________ Species ☐ Dog ☐ Cat ☐ Other ____________

Breed ____________ Color ____________

Sex ☐ M ☐ F Spayed/Neutered ☐ Yes ☐ No ☐ Unknown Microchipped ☐ Yes ☐ No

Reason for visit ______________________________

Previous Major Medical or Surgical Conditions ______________________________

Method of Payment

☐ Cash ☐ Check ☐ Visa/MC ☐ Discover ☐ Care Credit

Payment is due at the time service is rendered. No billing is offered.

I hereby grant to the veterinarian(s) in charge of the care of the patient described above, the authority to examine said patient in order to determine a course of treatment that he/she believes to be in the best interest of the patient. By agreeing to this examination, I consent to pay the fee associated with said examination. I also understand that any further treatments, testing or procedures deemed necessary or advised will be performed only after I have granted permission. My signature indicates that I am personally responsible for and will pay all charges incurred and I understand and will comply with Hill Top Animal Hospital policy that requires payment in full at the time of service.

Signature ______________________________ Date ____________

If you are transferring from another vet, please provide their name and phone number along with any previous vaccination records ______________________________