



New Client Form

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|-----------------|-------------|---------------------|-----------|
| First Name: | | Last Name: | |
| Street Address: | | City, State, & Zip: | |
| Home Phone: | Cell Phone: | Work Phone: | |
| Email: | | | Employer: |

If you choose not to enter an email address, you will not receive vaccine or appointment reminders.

How did you hear about us? _____

Previous Veterinarian: _____

TREATMENT AUTHORIZATION and INFORMATION RELEASE

I hereby authorize the veterinarian to examine, prescribe medicine for, or treat my pet and I assume full responsibility for all charges incurred in doing so. I understand that I can terminate treatment at any time by contacting the doctors and team. I also give Wags 2 Whiskers Veterinary Hospital permission to post my pet(s)'s picture, story, and medical information on social media for educational purposes.

FINANCIAL POLICY

Payment is due as services are rendered. For hospitalized cases, a deposit is required in advance. The remaining balance is due upon discharge from the hospital. You may pay by cash, personal check (with proper identification), or accepted credit cards. We will gladly prepare an estimate for services, upon request.

PRIVACY

Due to our client/patient confidentiality, we require you to print the names below to which we are allowed to share your pet's status and medical history during or after a treatment or procedure.

| | |
|----|----|
| 1. | 3. |
| 2. | 4. |

I understand that I (the owner or agent) am financially responsible to Wags 2 Whiskers Veterinary Hospital for all charges relating to this patient. I have read and agree to the treatment authorization and information release. I have also read and accept the financial policy.

Signature: _____ Date: _____