NEW PATIENT REGISTRATION

WELCOME! Thank you for the opportunity to care for your pet. Completing this form in advance and bringing it to your appointment will save you a considerable amount of time.

OWNER INFORMATION

TODAY'S DATE _____

YOUR FULL NAME _____
(FIRST, MIDDLE INITIAL, LAST)

STREET ADDRESS_____

CITY/ZIP CODE _____

EMAIL _____
(FOR MEDICAL RECORDS ACCESS, REMINDERS & COMMUNICATION ONLY)

YOUR CELL PHONE # _____

YOUR 2ND CONTACT PHONE # _____
( ) HOME ( ) WORK

SPOUSE/PARTNER FULL NAME _____

SPOUSE/PARTNER CONTACT PHONE # _____

PET INFORMATION

PET'S NAME _____

DATE OF BIRTH OR AGE _____

SPECIES _____

BREED _____

GENDER _____

NEUTERED/SPAYED _____

COLOR _____

MICROCHIP # _____

Veterinary practice to contact for prior medical & vaccination history _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?

FRIEND (NAME) _____

( ) SIGNAGE ( ) OUR WEBSITE ( ) WEB SEARCH ( ) PROMOTION/DIRECT MAILING ( ) COMMUNITY EVENT

MAY WE USE YOUR PET'S PHOTO ON OUR FACEBOOK PAGE OR BULLETIN BOARD? Yes ( ) No ( )

TREATMENT AUTHORIZATION & FINANCIAL POLICY

I hereby authorize the veterinarians of Atlantic Veterinary Hospital to examine, treat, and prescribe for my pet, described above. I understand the following:

- I am responsible for all charges involved in the care of this pet and **understand full payment is due at the time of service**. I will pay by cash, check, Visa, MasterCard, or Discovery.
- At my request, a Treatment Plan with the estimated cost for care will be provided for my approval.
- I may request complimentary assistance in completing pet insurance refund claims; however, I am responsible for the relationship with the pet insurance company.
- A $35 fee will be charged on all returned checks. A fee of $3 plus an interest charge of 1.5% will be added each month to all outstanding balances older than 30 days. If my account is more than 90 days past due, my information will be submitted to a bill collection agency, which may adversely affect my credit rating.

SIGNATURE OF OWNER_____