

New Client/Patient Form

Date				
Owner(s) Name				
	Last Name	First Name	M.I.	
Spouse/Other				
Home Address				
City	State	Zip		
Home Phone		Cell Phone		
May we send you text messages (pet updates, appointment reminders) and/or pictures of your pet while in our care? YES NO				
E-mail address	data.			
Emergency contact:	Ro	elation:	Phone	
How did you hear about us? If applicable, whom may we thank for referring you?				

PATIENT INFORMATION

NAME		
K9/FELINE		
MALE/FEMALE		
SPAYED/NEUTERED		
AGE/DOB		
BREED		
COLOR		

AGE/DOB					
BREED					
COLOR					
*If more than 4 pets, please ask for additional form.					
Do your pets have any previous medical history? YES NO					
If yes, where may we call for records?					

SOCIAL MEDIA/PHOTO/VIDEO RELEASE:

I, the undersigned, do hereby consent and agree that **The Veterinary Center at Hunter's Crossing**, its employees, or agents have the right to take photographs, videotape, or digital recordings of me and/or my pet and to use these in any and all media, now or hereafter known, and exclusively for the purpose of education and entertainment. I further consent that my name and identity may be revealed therein or by descriptive text or commentary. I do hereby release to **The Veterinary Center at Hunter's Crossing**, its agents, and employees, all rights to exhibit this work in print and electronic form publicly or privately and to market and sell copies. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used. I understand that there will be no financial or other remuneration for recording me and/or my pet, either for initial or subsequent transmission or playback. I also understand that **The Veterinary Center at Hunter's Crossing** is not responsible for any expense or liability incurred as a result of my participation in this recording, including medical expenses due to any sickness or injury incurred as a result. I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

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PLEASE INITIAL:	I AGREE	I DECLINE		
PERMISSION TO TREAT:				
for the pet identified above, cer and treatment of my pet by sta agree that after consultation wi hospitalize, anesthetize and/or	rtify that I am eighteen yea ff veterinarians at The Vete ith me, the hospital's docto	maritan responsible for seeking veterinary care are of age or over. I consent to the examination erinary Center at Hunter's Crossing. I also ors may prescribe medication for, treat, t.		
FINANCIAL POLICY:				
ROUTINE SERVICES AT THE TIM	E OF SERVICE. For your collised on the EOVER) for the amount of the EOVER)	re. PAYMENT IN FULL IS REQUIRED FOR ALL nvenience, we accept cash and credit/debit the invoice only. WE DO NOT ACCEPT		
A minimum of 50% of the estimate is required as a deposit at the time of admission for all major surgical procedures and hospitalizations. However, elective surgeries do not qualify and must be paid in full at the time of hospital release. Emergency cases require a minimum deposit of 50% of the written estimate at the time of admission. We offer Care Credit as a financing option for veterinary care (based on credit approval). In the event of non-payment, the pet owner agrees to bear the costs of finance charges at the rate of 1% per month, as well as the costs of all collection and/or court costs and legal fees, should this be required.				
Signature of Client Responsible	e for Pet(s)			

Date _____