



Curtis Road Animal Hospital
"Where we treat your pets like our own"

New Client Record
 Thank you for giving Curtis Road Animal Hospital an opportunity to care for your pet.

Owner _____ he/him, she/her, they/them
 Last, First Name Identifying Pronouns

Spouse _____ he/him, she/her, they/them
 Last, First Name Identifying Pronouns

Authorized owner representative or family members _____

Home Phone: _____ Cell Phone: _____

Email: _____ Spouse Cell: _____

Home/Mailing Address: _____
 Street Address

_____ City State Zip Code

Work Phone: _____. If necessary, may we call you at work? Yes/No

Driver's License: _____

How did you hear of us?

- Humane Society/Animal Shelter
- Internet/Website
- Hospital sign
- Groomer (specify): _____
- Boarding Kennel: _____
- Friend/Relative: _____
- Other: _____

Previous Veterinarian _____

May we contact them for your pet's medical records? Yes/No

I am the owner, or a representative of the owner, of the animal presented and I authorize the veterinarian(s) to examine, prescribe for, and/or treat said animal. I assume responsibility for all charges incurred in the care of this/these animal(s). I understand an estimate of fees will be provided at my request after an initial assessment has been made. I realize that actual expenses may differ from the estimate dependent on the patient's condition and length of stay in the hospital. Curtis Road Animal Hospital will make every effort to contact me if expenses exceed an accepted estimate.

All charges are to be paid at the time services are provided. A payment may be required in advance for major surgeries or extensive treatments. We accept Cash, Check, Visa, Mastercard and Discover card.

Any account with a No Show to a scheduled appointment is liable to a minimum charge of \$71.50, including but not limited to: same day appointment cancelation/reschedules. I agree to pay interest charges of 18% APR (1.5% per month) for any balance over 30 days past due. Should collections efforts become necessary, I further agree to pay the reasonable costs incurred in the process of collections. I also agree to pay a nonsufficient funds (NSF) fee of \$50 for any returned check.

Signature: _____ Date: _____