

HAWTHORNE ANIMAL CLINIC

Client/Patient Information

Client Information

Date _____

Name _____ Spouse/Co-Owner's Name _____

Address _____ City _____ State _____ Zip Code _____

Primary Phone _____ Work Phone _____ Cell Phone _____

Spouse/Co-Owner's Primary Phone _____ Work Phone _____ Cell Phone _____

Place of Employment (Primary) _____ Place of Employment (Spouse) _____

Please provide your email address so we are able to send reminders for your pet via email.

Email Address _____

Patient Information

Patient Name _____ Date of Birth _____ Sex _____ Neutered? Y / N

Species _____ Breed _____ Color _____

Name/Brand of Food _____ Feeding Amount/Schedule _____

Medications/Supplements and Dosage _____

Previous Illnesses _____

Allergies (vaccines, etc.) _____

Patient Name _____ Date of Birth _____ Sex _____ Neutered? Y / N

Species _____ Breed _____ Color _____

Name/Brand of Food _____ Feeding Amount/Schedule _____

Medications/Supplements and Dosage _____

Previous Illnesses _____

Allergies (vaccines, etc.) _____

Patient Name _____ Date of Birth _____ Sex _____ Neutered? Y / N

Species _____ Breed _____ Color _____

Name/Brand of Food _____ Feeding Amount/Schedule _____

Medications/Supplements and Dosage _____

Previous Illnesses _____

Allergies (vaccines, etc.) _____

Please complete back of form.

Previous Treatment

It is very important that your pet's primary veterinarian is aware of ALL treatments/medications/vaccinations your pet has received. Please list all veterinarians, along with contact information, that have given treatment to your pet.

Veterinarian _____ Clinic Name _____ Phone _____
Veterinarian _____ Clinic Name _____ Phone _____
Veterinarian _____ Clinic Name _____ Phone _____

Financial Agreement

Payment is due today for outpatient services, If your pet is here for surgery, hospitalization, or boarding, a deposit may be required and the balance will be due when your pet goes home.

FINANCIAL RESPONSIBILITY AGREEMENT: I/we understand that if any unpaid balanced is assigned to a third party collection agency for collection or placed with an attorney to obtain judgement or otherwise satisfy payment of my account, a collection fee of 33 1/3 % will be added to my account. I/we agree to pay that fee. I/we further agree to pay reasonable attorney fees and court costs. I agree that by providing a cell phone number on this form, I/we am providing my consent to have you or your agents call me at that number from this date forward. I/we understand and agree to the above terms.

- I authorize the release of pertinent medical records to other medical/boarding/grooming facilities if I request them to be released in the future.
- I authorize that I have seen and read the Financial Agreement for Hawthorne Animal Clinic.

Signature of responsible party

Date

Signature of responsible party

Date

All fees are due at the time services are rendered.