HICKMAN RUN ANIMAL HOSPITAL

202 E. GRAFTON RD., FAIRMONT, WV 26554 (304)333-6365

NEW CLIENT INFORMATION

OWNER'S NAME: _____

ALTERNATE CONTACT/CO-OWNER:

_____

PHYSICAL ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MAILING ADDRESS (if different from above):

_____

CITY: _____ STATE: _____ ZIP: _____

PRIMARY PHONE: _____ cell home

SECONDARY PHONE: _____ cell home

EMAIL: _____

DRIVER'S LICENSE # (REQUIRED FOR CHECKS): _____

EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER'S PHONE: _____

.....

PREFERRED METHOD OF PAYMENT(S): **MARK AN X**

CASH CHECK VISA/MC/DISCOVER CARE CREDIT

.....

HOW DID YOU HEAR ABOUT US? CHECK ALL THAT APPLY

NEWSPAPER/INTERNET/YELLOW PAGES AD

TELEVISION COMMERCIAL

SAW THE SIGN/CONVENIENT LOCATION

HEARD GOOD THINGS ABOUT THE FACILITY AND STAFF MEMBERS

WAS IMPRESSED WITH THE STAFF WHEN I CALLED

RECOMMENDED BY A FRIEND: _____

CLIENT ID#

NEW PET

PET'S NAME: _____

SPECIES: CAT DOG

BREED: _____

GENDER: MALE NEUTERED MALE FEMALE SPAYED FEMALE

DATE OF BIRTH (OR AGE): _____

COLOR(S): _____

LIST ANY PREDOMINANT MARKINGS: _____

_____

MICROCHIP/TATOO #: _____

LIST ANY SIGNIFICANT HEALTH PROBLEMS OR DRUG ALLERGIES:

_____

_____

_____

WHEN WAS YOUR PET LAST VACCINATED?

DISTEMPER: _____ RABIES: _____

HAS NOT RECEIVED ANY

REASON FOR TODAY'S VISIT:

_____

_____

_____

_____

_____

_____

_____

I hereby authorize Hickman Run Animal Hospital to do whatever is necessary to care for my pet in case of illness or emergency situation. I agree to pay in full for services rendered, including those deemed necessary for medical or surgical complications or unforeseen circumstances. I understand that the services of Hickman Run Animal Hospital must be paid for, in full, before my pet will be released to me. I also agree to pay for any reasonable attorney fees in the event of collection proceedings for any unpaid balance.

SIGNED: _____ DATE: _____