**COMPANION ANIMAL CLINIC**

**DOUG EVANS, D.V.M. CARRIE CASITA, D.V.M. VARINA ACOSTA D.V.M.**

**CLIENT INFORMATION**

**PLEASE PRINT CLEARLY**

ID#\_\_\_\_\_\_\_\_\_\_  ENTERED BY:\_\_\_\_\_\_\_\_\_\_\_\_

 (OFFICE USE ONLY) (OFFICE USE ONLY)

OWNER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAST FIRST MIDDLE

CO-OWNER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAST FIRST MIDDLE

BEST PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OTHER PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MAILING ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#STREET CITY STATE ZIP

EQUEST.HORIZE COMPANION ANIMAL CLINIC TO SHARE RECORDS WITH OTHER CLINICS, SHELTERS & LEGITIMATE LOCAL AUTHORITIES UPON

*HOME ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*(IF DIFFERENT THAN ABOVE) # & STREET CITY STATE ZIP*

OWNER EMPLOYER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

COMPANY PHONE # POSITION

CO-OWNER EMPLOYER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

COMPANY PHONE # POSITION

IN CASE OF EMERGENCY\* :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \*NAME/PHONE# OF FRIEND/RELATIVE NOT IN HOUSEHOLD

HOW DID YOU HEAR ABOUT US:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAYMENT IS REQUIRED AT TIME OF SERVICE**

PAYMENT OPTIONS ARE: **CASH/VISA/MASTERCARD/DISCOVER/CARE CREDIT** ***(CHECKS NOT ACCEPTED)***

**\*\*A $25.00 “MISSED APPOINTENT FEE” WILL BE APPLIED TO ANY ACCOUNT WITHOUT A MINIMUM OF 12 HOUR CANCELATION NOTICE.**

**\*\* TO AUTHORIZE TREATMENT OWNER/AGENT MUST BE AT LEAST 18 YEARS OR OLDER. AUTHORIZTION IS GIVEN TO COMPANION ANIMAL CLINIC TO SHARE RECORDS WITH OTHER CLINICS,**

**SHELTERS, & LEGITIMATE LOCAL AUTHORITIES UPON THEIR REQUEST.**

**\*\*A $25.00 FEE WILL BE APPLIED TO ANY FRAUDULENT METHOD OF PAYMENT**

***\*\* Subject to change without notification***

**BY SIGNING THIS DOCUMENT, I AGREE TO THE ABOVE TERMS, AND HAVE**

**RECEIVED & REVIEWED THE NEW CLIENT LETTER.**

\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE SIGNATURE OF OWNER/AGENT**

 **NEWCLIENTFORM 100819**