



# Welcome, New Clients & Patients!

**We are so excited you are here!**



To ensure the best care possible, please take the time to fill out this form completely. Thank you for giving us the opportunity to care for your pet(s). As you may already know, we are accredited by the American Animal Hospital Association (AAHA) which means your pet(s) will be cared for by a team of veterinary professionals included in the top 10-15% of all veterinary hospitals in the U.S. and Canada! We'll be happy to answer any questions you may have about your pet's health.

**Thank you and welcome to our veterinary practice!**

## OWNER INFO

Primary Owner\* \_\_\_\_\_ Phone \_\_\_\_\_ (Circle One) Home / Cell / Work

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Email (to receive reminders about appointments, vaccinations, etc.) \_\_\_\_\_

*\* Primary Owner's will be the automatic contact for emergencies and health/financial updates.*

Spouse/Co-Owner \_\_\_\_\_ Phone \_\_\_\_\_ (Circle One) Home / Cell / Work

### How would you prefer we contact you:

- For upcoming medical services? *Email OR Postcard*
- For an appointment reminder? *Text/Email OR Call*
- To check-in on your pet after vaccines, procedures, or hospital stay? *Call / Text / Email*

How did you hear about us? *Ad Family/Friend Online Search Social Media Other:* \_\_\_\_\_

If someone recommended us, whom can we thank? \_\_\_\_\_

## PET INFO

Pet's Name	Species	Breed	Sex: F / M	Spayed / Neutered?	DOB / Age	Color
1						
2						
3						
4						
5						



# AUTHORIZATION

## If you are transferring care or have been referred from another veterinary facility:

My pet's previous veterinarian/facility was: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Records to Release:  Vaccination History Only  Entire Medical History

The above veterinary office will provide the history/record type requested above to us at :  
*adairanimalhospital@gmail.com or faxed to (270) 384-6113*

I hereby certify that I am the owner or authorized agent of the owner of the described pet(s) on this form. Further, I hereby request and authorize the former listed facility to release the requested medical information for my pet(s) to Adair County Animal Hospital and Laser Surgery Center. I release the former veterinary facility and staff from any and all legal liability for the release of information to the extent indicated and authorized herein.

## May we use your pet's photo for social media and/or marketing material? Yes / No

I hereby authorize the veterinarian to examine, prescribe for, or treat any animals I bring to the hospital for care, including but not exclusive to the ones listed on this form. I assume responsibility for all charges incurred in the care of all animals listed under my account. I also understand that these charges will be paid at the time of release and that a deposit may be required for extensive care or surgical treatment. We offer Care Credit, Scratch Pay, and All Pet Card if a payment plan is necessary and only accept CASH or CREDIT CARD for first time visits. Credit card payments will incur a typical transaction fee of approximately 3%-5%.

Estimates include items our staff will most likely require to treat and care for your pet during their treatment. Please understand the treatment plan / estimate is an approximation only. The final cost may vary from the estimate provided. We routinely provide written estimates upon request, and your medical team will discuss that estimate with you prior to treatment. Our team will make every effort to inform you, the primary client listed on the account, of ongoing costs; however, it is your responsibility to ask a staff member for updates on your invoice total.

You agree to reimburse us the collection fees of any collection agency, which shall be based on a percentage at a maximum rate of 33.3% of the amount due at the time your account is placed with a collection agency, and all costs and expenses incurred for any collection efforts on your account, including reasonable attorney's fees incurred by the collection agency. This contract shall cover all medical treatment and services until revoked by either party in writing.

All clients that create an account or are listed as primary clients on an account at our hospital must be 18 years or older. By signing below, I also acknowledge that I am 18 years of age or older.

Driver's License # or State ID # \_\_\_\_\_ State Issued: \_\_\_\_\_

Name on Driver's License \_\_\_\_\_

Owner's Signature \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_