



1933 St. Joseph Dr. NW | Cullman, AL 35055
256-734-5557

NEW CLIENT FORM

Thank you for giving us the opportunity to care for your pet(s). So that we may become better acquainted, please complete the following information sheet. State and Federal Law requires you must be 18 to complete this form.

CLIENT INFORMATION

Owner's Name _____ Spouse/Co-Owner's Name _____

Owner's Driver's License # _____ State: _____

Address _____ City _____ State _____ Zip _____

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

Place of Employment _____ Best Time to Reach You _____

E-mail Address: (Provide only if you would like us to contact you regarding your pet's health care) _____

In case of EMERGENCY, call _____ at phone #:

We will gladly prepare a written estimate if you so desire. Please ask any staff member or doctor. Professional fees are due at time services are rendered.

Preferred Method of Payment: Cash Credit/ Debit Check Care Credit

How did you become aware of our clinic? Drove by ___ Social Media ___ Web Site ___ Hospital Sign ___ Another

Hospital? If so, which? _____ Personal Recommendation (Whom may we thank?) _____

How Would You Like To Be Reminded of Future Recommended Preventive Health Care Services For Your Pet?

Phone/Text Mail E-mail Both Phone & Mail

I understand every effort will be made to achieve a successful outcome and to provide for all possible safety in hospital care and handling. I hereby authorize this hospital to receive, prescribe for, treat or perform surgery upon the pet(s) listed and additional pets I present. Furthermore, I agree to pay fees for services rendered at the time the pet is discharged from the hospital or the service is otherwise terminated. I agree to pay for the reasonable costs of collection in the event that collection efforts become necessary. I understand that a service fee of \$30.00 will be assessed for each non-sufficient fund check and/or certified letter that must be sent. All accounts unpaid after 30 days receive a \$5.00 Billing Charge each month and a late charge computed at a periodic rate of 1.5% per month, which is an annual percentage rate of 18.00% with a minimum monthly charge of \$1.00. I understand that veterinary service is provided during nighttime hours as necessary in the judgment of the veterinarian in charge. Continuous presence of qualified personnel may not be provided. If I neglect to pick up my pet within 5 days of the discharge date and do not notify you within that time period, you may assume that the pet is abandoned and are hereby authorized to dispose of the pet as you deem best and/or necessary. I understand that by signing below, I am claiming to be the owner of this animal and thereby accepting financial responsibility for the above animal(s).

Signature _____ Date _____

	PET # 1	PET # 2	PET # 3
NAME			
BREED			
DATE OF BIRTH			
COLOR			
SEX; SPAYED OR NEUTERED?			
YOUR DOG'S VACCINATION HISTORY:			
RABIES			
DHLP PARVO			
BORDETELLA			
FECAL (STOOL SAMPLE)			
HEARTWORM TEST/PREVENTION			
YOUR CAT'S VACCINATION HISTORY:			
RABIES			
DIST-RHINO CHLAMYDIA			
LEUKEMIA TEST			
FECAL (STOOL SAMPLE)			

Our pet(s) is: Indoor Only Outdoor Only Equally Indoor/Outdoor A Child's Pet

Any previous serious illnesses or surgeries? _____

Any allergies to vaccinations or medications? _____

Is your pet on any special diets or medications? _____

I grant Northside Veterinary Hospital permission to post my pet's picture, story and medical information on social media.

Signature _____ Date _____

