

## **New Client Registration**

Dr. Adam Carter, DVM

Dr. Lisa Stacey, DVM

Dr. Nicole Kuhlmann, DVM

Thank you for choosing our animal hospital. We take pride in ourselves in offering high quality medical care and emphasize preventive medicine. We look forward to serving you and caring for your pet's needs. Please complete this form so we can accurately enter this information into our files. Please print clearly.

Owner(s)					
Last Name	First Name				
Street Address		City		Zip Code	
Home Phone Number Cell/Page		nber	Owner D.O.	В	
*If you would like to be con  ☐ Alltel ☐ AT&T ☐ N	extel	Verizon D E	Boost Mobile 🗆 Vi	rgin MobileUSA	
Employer Wo	ork Number	E-mail	Address (for patient re	minders)	
Spouse's First Name	Last Name		_		
Employer	Work Number		Cell/Pager Number		
How did you hear about u	s? (Circle one pleas	ee)			
Phone Book Our Sign	Internet Other:		Referral From:		
Today's Date:					
I.D. Verified: Employee	's Initials				

## FINANCIAL RESPONSIBILITY AGREEMENT:

I hereby authorize West Gate Veterinary Hospital Professional Staff to examine, treat, and utilize procedures or test deemed necessary for my pet(s) to ensure the best possible care.

I assume responsibility for all charges incurred to my pet(s). I understand that payment is due at the time services are rendered and/or at the time of the pet's discharge. If I am unable to pay in full, I must notify West Gate Veterinary Hospital prior to treatment.

Should my pet be hospitalized or require extensive treatment, I will receive an estimate of the cost and **before I leave I agree to pay the required 50% of the estimated cost** and pay the remaining balance when the pet is discharged.

A non-payment will be considered default after (5) five days overdue and a late charge of 18 % APR monthly will be applied to all unpaid balances plus any collections and/or reasonable attorney fees that incurred in an attempt to collect this debt. Acceptable payment types are: Cash, Checks, Debit Cards, Visa, Master Card, Discover, American Express, and Care Credit Cards.

In accordance with the privacy act, I understand my rights for privacy and that personal information will not be released without my consent.

I certify and authorize West Gate Veterinary Hospital to disclose the necessary information required, for the continuing good health of my pet(s), with other veterinarians, specialists, and other related third parties.

I certify that all the information is correct and I have read and understand the above information and agree to the payment terms.

Owner's/Agent's Signature:	Date:
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## **Patient Registration:**

Pet One:						
Pet's Name		Species: Ca	ınineF	eline Ot	her:	
D.O.B. or Age	Breed			Color/Markin	ngs	
Gender: Male:	Neutered	Not Neutered	Female	:Spayed_	Not Spayed	
Is your pet on ar	ny special diet o	or medications?				
Are there any pre	evious health/bo	ehavior issues we	should be a	ware of?		
Vaccine History	: Not Curr	rent Curren	nt (Please p	rovide vaccin	ation records)	
Pet Two:						
Pet's Name		Species: Ca	anineF	eline Ot	her:	
D.O.B. or Age	Breed			Color/Markin	Color/Markings	
Gender: Male:	Neutered	Not Neutered	Female	e: Spayed	Not Spayed	
Is your pet on ar	ny special diet o	or medications?				
Are there any pre	evious health/bo	ehavior issues we	should be a	ware of?		
Vaccine History	: Not Curr	ent Currei	nt (Please p	rovide vaccin	ation records)	
boarded animal	s, to include be ernal parasite	etious diseases and aths, must be cur s. I authorize the my pet(s).	rent on all	vaccines and	free of	
Owner's/Agent's	Signature:			Date:		