ATLANTIC Veterinary Hospital

For Office Use
DATE: ________
Client # ________
Recept.________

Last Name: ______________________ First Name: ______________________

Address: ____

City: ______________________ State: ________ Zip Code: ________

Home Phone: ( ) ______________ Cell Phone: ( ) ______________

S.S. # ______________________

Employer: ______________________ Work Phone: ( ) ______________

E-Mail: ____

Spouse: ______________________ Phone: ( ) ______________

Emergency Contact: ______________ Phone: ( ) ______________

I UNDERSTAND THAT FEES ARE DUE AT TIME SERVICES ARE RENDERED.

I HEREBY AUTHORIZE THE VETERINARIAN TO EXAMINE, PRESCRIBE FOR, AND/OR TREAT THE DESCRIBED PET BELOW.

SHOULD IT BECOME NECESSARY TO COLLECT THIS AND ANY FUTURE AMOUNTS THROUGH AN ATTORNEY, THE UNDERSIGNED AGREES TO PAY ALL COSTS OF COLLECTION, INCLUDING A REASONABLE ATTORNEY'S FEE. IF THIS ACCOUNT IS ASSIGNED TO A COLLECTION AGENCY, AN ADDITIONAL FEE OF 35% OF THE AMOUNT OWED WILL BE ADDED.

Driver's License No.: ____

Signature: ____

Date of Birth: ______________

Pet Health History

Name of Pet:

______________________ Dog ☐ Cat ☐ Oth- ☐ er ______________

Breed: ______________________ Color: ______________ Birthdate: ______________

☐ Male ☐ Neutered ☐ Female ☐ Spayed

Symptoms: ____

Current Medications ____

Pet's Diet: ____