



Date: _____

Chemstrand Oaks Veterinary Hospital New Client Form

Owners Last Name: _____ First Name: _____ Spouse (Other): _____

Address: _____ City: _____ State: _____ Zip: _____

Home#: _____ Cell#: _____ Work#: _____

Spouse (other)#: _____ Email: _____

Driver's License Number (For Checks): _____ D.O.B.: _____

HOW CAN WE CONTACT YOU?

Text Reminders? Yes ___ No ___ Email Reminders? Yes ___ No ___ Phone Reminders? Yes ___ No ___

How did you become aware of Chemstrand Oaks? (referral, web, sign, etc.) _____

Patient #1

Name: _____

DOB or Age: _____

Species: Cat or Dog

Sex: Female or Male

Spayed or neutered: Yes or No

Breed: _____

Color: _____

Allergies: _____

Diagnosed injury or illness: _____

Previous surgeries: _____

Current medications: _____

Patient #2

Name: _____

DOB or Age: _____

Species: Cat or Dog

Sex: Female or Male

Spayed or neutered: Yes or No

Breed: _____

Color: _____

Allergies: _____

Diagnosed injury or illness: _____

Previous surgeries: _____

Current medications: _____

We pledge to do our best to care for your pet's health needs. In return, we ask you to accept responsibility for all charges incurred in treatment of your pet and accept payment due when services are rendered. Please feel free to ask for an estimate prior to providing services. If at any time you are not satisfied with our service, let us know. We are happy to answer any question you may have.

Treatment Authorization: I am the owner/authorized agent for the animal named above, and I am 18 years of age or older. I give permission for the staff of Chemstrand Oaks Veterinary Hospital to examine and treat my pet as I have requested. I understand that medical therapy of any kind involves some risk to my pet, including but not limited to adverse drug reactions, and agree to hold the hospital and its employees harmless in the absence of negligence, in connection with these procedures. I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained. In the event of an emergency I understand that life saving measures will be initiated while an attempt is made to contact me. If I cannot be contacted at the listed numbers, the doctor and staff are directed to make decisions deemed best for my pet. **I understand that payment is due when services are rendered, and I agree to pay for those services rendered.**

Media Release Authorization: By selecting YES, you agree to release Chemstrand Oaks Veterinary Hospital and staff of liability for any violation of any personal or proprietary right in taking/using photographs in publication, print ads, direct mail piece, electronic media (e.g. video, CD-ROM, world wide web) or other form of promotion. Yes No

I have read and understand the foregoing, and agree

Signature _____ Date _____