# Cascade Veterinary Clinic

## PATIENT/CLIENT INFORMATION FORM

Thank you for giving us the opportunity to care for your pet. Please help us better meet your needs by taking a few moments to fill out this information sheet.

### CLIENT INFORMATION

Owner's Name: _____ Spouse/Other: _____

***Mailing Address:*** _____ City: _____ State: ____ Zip: _____

Physical Address: _____ City: _____ State: ____ Zip: _____

Home Phone #: _____ Work Phone #: _____

Email Address: _____

Employer's Name and Address: _____

At what time is it best to call about your pet _____ and at what phone # _____

In case of EMERGENCY, call _____ at phone # _____

Name of Previous/Current Veterinarian: _____

May we contact them and request a copy of your pet's records? ☐ Yes ☐ No

### FINANCIAL INFORMATION

We will gladly prepare a written estimate if you so desire. Please ask a receptionist or doctor. Professional fees are due at time services are rendered. If you wish to pay by check or credit card, please complete the following:

Preferred Method of Payment: ☐ Check ☐ Credit Card

Bank Name: _____ Driver's License #: _____

Owner's Social Security #: _____ Spouse/Other SSN: _____

### HOW DID YOU HEAR ABOUT OUR PRACTICE?

How did you hear of our hospital?

☐ Individual, someone we may thank? _____

☐ Hospital sign?

☐ Another hospital? (Please specify.) _____

☐ Yellow pages or another telephone directory?

☐ Other? (Please specify.) _____

Would you like to be on our mailing list? ☐ Yes ☐ No

(If so, you will receive timely reminders when your pet's vaccinations, examinations, etc., are due.)

To help prevent the spread of infectious diseases, ALL hospitalized and boarded animals must be current on all vaccinations.

I (OWNER) 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 my pet(s). 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.

In the event that I become delinquent and payment is not made on amounts owning under the terms of this agreement, and the balance is placed with a licensed collection agency, I agrees to pay the fees of the collection agency, which amount is theretofore agreed to be 50% of the outstanding balance at the time the account is placed for collections. The 50% collection agency fee will be calculated and added at the time the account is placed into collections.

Signature: _____ Date: _____