Kimberly Crest Veterinary Hospital

New Client/Companion Information

Thank you for giving us the opportunity to help care for your companion.
Please help us become better acquainted by providing the required information below.

Primary Contact Information

Last Name: _____ **First Name**: _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Primary Phone: _____ **Social Security #**: _____ - _____ - _____
☐ Cell ☐ Home

Contact Preference for Appointment Reminders:
☐ Phone ☐ Email ☐ Text Message

Note: it is not mandatory to give your SS #. However, we are unable to take personal checks without it.

Driver's License # *(required for check)*: _____ **Birthday**: ____/____/____

Employer: _____ **Work Phone**: _____
May we contact you at work for non-emergencies?
☐ Yes ☐ No

Email Address: _____

Secondary Contact Information

Last Name: _____ **First Name**: _____

Primary Phone: _____ **Work Phone**: _____
May we contact you at work for non-emergencies?
☐ Yes ☐ No

Relation to Primary Contact: _____ **Birthday**: ____/____/____

Emergency Contact Information

First & Last Name: _____ **Primary Phone**: _____

How did you become aware of our Hospital?

☐ Individual, someone we may thank? _____
☐ Yellow Pages ☐ Hospital Sign ☐ Humane Society
☐ Internet or Website ☐ Our Brochure ☐ Facebook

Are there medical records you would like transferred from another hospital/clinic?
If yes, Clinic Name _____ Phone _____

Do you have Pet Insurance? ☐ Yes ☐ No
Provider: _____ Policy # (*if known*): _____

Companion Information

COMPANION #1

Name_____ **Breed**_____

Age/Date of Birth_____ **Sex** □ Male □ Female **Spayed/Neutered** □ Yes □ No

Color_____ **Current medications** _____

Diet/Pet Food_____ **Vitamins/Treats**_____

What type of heartworm prevention is your companion on? _____

What type of flea and tick prevention is your companion on? _____

Does your companion have a tattoo or microchip? □ Yes □ No #_____

COMPANION #2

Name_____ **Breed**_____

Age/Date of Birth_____ **Sex** □ Male □ Female **Spayed/Neutered** □ Yes □ No

Color_____ **Current medications** _____

Diet/Pet Food_____ **Vitamins/Treats**_____

What type of heartworm prevention is your companion on? _____

What type of flea and tick prevention is your companion on? _____

Does your companion have a tattoo or microchip? □ Yes □ No #_____

PLEASE LET US KNOW IF YOU HAVE MORE THAN TWO PETS

AAHA ACCREDITED — The Standard of Veterinary Excellence

Cat Friendly Practice® By the American Association of Feline Practitioners

ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. Outstanding balances will be subject to a 1.5% monthly service charge (18% APR) in addition to a billing fee of $2.85 monthly. Any account requiring collection activity will also be subject to reasonable cost of collection and all legal fees and court costs. A return check fee of $30 per return will be charged for any returned check. 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, treat or perform surgery upon pet(s) listed. **I agree to the terms and conditions and have provided all of the required information.**

_____ _____

Companion Owner's Signature Date

Staff Use Only

Client #: _____ Staff Initials: _____