



## New Patient and Client Information Sheet

Welcome to Trail Animal Hospital. Our mission is to provide our clients with the very best loving, compassionate veterinary health and wellness care from before hello to beyond good-bye.

### Client Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Primary Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Emergency Contact/Spouse/Partner: Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

### Patient Information

Pet's Name: \_\_\_\_\_ Sex: Male Female Neutered or Spayed? Yes No  
 Species: Dog Cat Other: \_\_\_\_\_  
 Pet's date of Birth (Month/Day/Year): \_\_\_\_/\_\_\_\_/\_\_\_\_ Breed: \_\_\_\_\_ Color: \_\_\_\_\_  
 Reason for bringing pet in: \_\_\_\_\_  
 Does your pet have any allergies, special medications, or health problems we should know about? Yes No  
 If yes, what? \_\_\_\_\_

Is your pet up to date with vaccines? Yes No  
 Who is your previous veterinarian? \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

### Patient Information

Pet's Name: \_\_\_\_\_ Sex: Male Female Neutered or Spayed? Yes No  
 Species: Dog Cat Other: \_\_\_\_\_  
 Pet's date of Birth (Month/Day/Year): \_\_\_\_/\_\_\_\_/\_\_\_\_ Breed: \_\_\_\_\_ Color: \_\_\_\_\_  
 Reason for bringing pet in: \_\_\_\_\_  
 Does your pet have any allergies, special medications, or health problems we should know about? Yes No  
 If yes, what? \_\_\_\_\_

Is your pet up to date with vaccines? Yes No  
 Who is your previous veterinarian? \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

### How did you become aware of our hospital?

Referred by a friend: Whom may we thank? \_\_\_\_\_  
 Drove By Yelp/Google Website/Social Media Other: \_\_\_\_\_

**For your convenience, we accept Cash, MasterCard, Visa, Discover, American Express and Care Credit.**



**TRAIL ANIMAL**  
HOSPITAL  
SINCE 1957



## Hospital Policy

**You are responsible for payment of all services rendered at the time such services are performed.** Treatment plans will be provided for any services upon request. A deposit is required prior to hospitalization/surgery and the account must be kept current throughout the period of hospitalization.

### Appointment Policy

If you need to cancel an appointment, notify our office within 24 hours.

Initials: \_\_\_\_\_

### Policy Concerning Abandoned Pets

If you do not pick up your pet within ten (10) days of the release date, your pet will be considered abandoned. You will be billed for the treatments and boarding costs incurred up to the date that you pick up your pet.

Initials: \_\_\_\_\_

### Authorization

To the best of my knowledge this information is correct. I understand that fees are due and payable at the time service is rendered. This debt was incurred as a result of treatment and care requested and authorized by me. I understand and agree that I will pay the collection costs, in addition to interest, court costs and reasonable attorney fees associated with collection of any overdue or unpaid balance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Thank you for allowing us to take care of your pet. We know that you find that we treat every patient as a part of our family at Trail Animal Hospital.**