# WELCOME

## Newberg Veterinary Hospital Client & Patient Information Sheet

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as possible. We look forward to working with you and caring for the needs of your pets.

## Client Information

Name ______________________________________________ Home Phone:__________________________
Last First Initial

Physical Street Address__________________________________________ Cell /Pager #__________________

Mailing Address (if different from above) or PO Box_____________________________________________________

City ______________________________ State ________ Zip Code ________________

Do you qualify for a Senior Citizen Discount? (Over 65Yrs of Age) __________

Drivers Lic# _____________________ State Issued____ Birth date __________ Social Sec#_________________

Employer____________________________________Phone____________________Occupation____________

Employer Address ______________________________City _________________State____ Zip Code_________

Spouse ____________________________________________ Cell /Pager #: __________________________
Last First Initial

Physical Street Address__________________________________________ Cell /Pager #__________________

Mailing Address (if different from above) or PO Box_____________________________________________________

City ______________________________ State ________ Zip Code ________________

Drivers Lic# _____________________ State Issued____ Birth date __________ Social Sec#_________________

Employer____________________________________Phone____________________Occupation____________

Employer Address ______________________________City _________________State____ Zip Code_________

***Notify in case of an emergency*** _________________________________________________/______________
Last First Initial Relationship to You

***Home Phone:*** ____________________ ***Cell/Pager:*** _____________________ ***Work Phone:***______________

How did you select us? ___________________________Whom may we thank? ___________________________

Please provide us with your e-mail address ________________________________________________________

### HOSPITAL POLICIES

To provide the best care for your pets, we require that ***ALL** hospitalized, boarded, and groomed pets **MUST** be current on all of their vaccinations and be free of internal and external parasites.* The signature below authorizes this level of preventive care and the appropriate charges will be assessed on the discharge invoice.

ALL PROFESSIONAL FEES ARE DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED

In cases of extensive medical or surgical procedures, and when full payment may be difficult at discharge, we accept:
MasterCard, Visa, Discover, American Express, Personal Checks and Cash
*We will prepare a written estimate upon request prior to any treatment or surgery.*

** I/We understand and agree that any credit granted shall be paid promptly in accordance with the terms and agreements and that the credit grantor may add 1½% per month to any balance owed and in event of default to pay reasonable collection charges and/or attorney fees. There will be a $25.00 service fee for any check returned to us unpaid. ** I/We have read the above information and understand fully to what I am signing.

Signature of Responsible Agent(s) ___________________________________________ Date _____________

Signature of Responsible Agent(s) ___________________________________________ Date_____________