New Client / Patient Form

Welcome to Inman Park Animal Hospital. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you. We look forward to working with you in maintaining your pet's health.

OWNER INFORMATION: ▢ Dr. ▢ Mr. ▢ Mrs. ▢ Ms.

Last Name: _____ First Name: _____

Address: _____ County (check one): ▢ Fulton ▢ Dekalb

City: _____ State: _____ Zip: _____ ▢ Other county _____

Primary phone: _____ This is a… ▢ Cell ▢ Home ▢ Work

Secondary phone: _____ This is a… ▢ Cell ▢ Home ▢ Work

Email address: _____

Additional person to add to your account, if applicable:

Last Name: _____ First Name: _____ Cell phone:_____

Relationship (check one): ▢ Spouse ▢ Significant other ▢ Co-owner ▢ Relative ▢ Friend ▢ Other

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How did you find out about Inman Park Animal Hospital? (select one) ▢ Ahimsa House ▢ Community Event ▢ Dr. Ellard ▢ Dr. Fowler ▢ Dr. Kumar ▢ Emergency Clinic ▢ Employee (non-DVM) ▢ Facebook ▢ Google ▢ Other Web Search ▢ Sign/Drove By ▢ Veterinary Specialist ▢ Word of Mouth ▢ Yellow Pages ▢ Yelp ▢ Specific person -- Please tell us who we can thank: _____

We love social media! We may wish to to share your pet's image and story on social media, our website, and other forms of related media and educational materials. Your full name and personal information will never be shared. **Choose one:**

▢ *Yes, I authorize Inman Park Animal Hospital to share my pet's photo and story at any time.*

▢ *No, I do not consent to have my pet's image and/or story shared.*

TREATMENT CONSENT: By completing this form, you authorize the veterinarian(s) to examine, diagnose, and treat the below-described pet(s) to the best of their abilities. All in-patients must be current on vaccines and free from parasites. To comply with this policy, certain treatments may be necessary to protect the health and safety of all pets in our care. You assume responsibility for all charges incurred in the care of your pet(s).

FINANCIAL POLICY: We accept Visa, Mastercard, Discover and American Express, cash and checks. Full payment is due at the time of service. Clients with payment concerns are asked to speak to a staff member before the exam. We are happy to provide you with a written treatment plan prior to services being rendered. No payment plans are offered.

Your signature below indicates your agreement with hospital policies and all other information listed above.

TURN PAGE TO COMPLETE PET INFORMATION

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Signature: _____ Date: _____

PET INFORMATION:

Pet Name: _____ Species (check one): ▢ CANINE ▢ FELINE

Breed: _____ Date of birth or approximate age: _____

Sex: ▢ Neutered male ▢ Spayed female ▢ Male (intact) ▢ Female (intact)

Color: _____ Microchip # (if present/known): _____

Allergies and/or medical problems: _____

Previous Veterinary Practice Name: _____ Phone: _____

**Please provide records from your previous veterinarian*

SECOND PET INFORMATION:

Pet Name: _____ Species (check one): ▢ CANINE ▢ FELINE

Breed: _____ Date of birth or approximate age: _____

Sex: ▢ Neutered male ▢ Spayed female ▢ Male (intact) ▢ Female (intact)

Color: _____ Microchip # (if present/known): _____

Allergies and/or medical problems: _____

Previous Veterinary Practice Name: _____ Phone: _____

**Please provide records from your previous veterinarian*

THIRD PET INFORMATION:

Pet Name: _____ Species (check one): ▢ CANINE ▢ FELINE

Breed: _____ Date of birth or approximate age: _____

Sex: ▢ Neutered male ▢ Spayed female ▢ Male (intact) ▢ Female (intact)

Color: _____ Microchip # (if present/known): _____

Allergies and/or medical problems: _____

Previous Veterinary Practice Name: _____ Phone: _____

**Please provide records from your previous veterinarian*
