

Welcome to Canyon Pet Hospital

Thank you for the opportunity to care for your pet. We will be happy to answer any questions you may have about your pet's health. To insure the best possible care, please take time to fill out our information form completely. You must be 18 years of age to complete this form.

PLEASE PRINT CLEARLY. Thank you.

Client / Owner Information

Last Name _____ First Name _____

Spouse/Co-owner (s) _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail _____

May we use your e-mail address to send you reminders? Yes _____ No _____

Employer _____ Work Phone _____

Emergency Contact _____ Phone # _____

How did you hear about us? Yellow Pages ____ Internet ____ Newspaper ____ Radio ____ TV ____

Humane Society ____ Petland ____ Second Chance ____ Word of mouth ____ Other _____

If one of our clients referred you please let us know so we can thank them _____

<i>Pet Information</i>	<i>Pet #1</i>	<i>Pet #2</i>	<i>Pet #3</i>
Name			
Species			
Breed			
Color			
Birthdate / Age			
Gender	Male / Female	Male / Female	Male / Female
Neutered / Spayed	Yes / No	Yes / No	Yes / No
Previous Veterinarian			
Date of last vaccinations			
Current medications			
History of seizures			
Any known allergies			

Please provide previous medical records for extensive medical history and medications

Authorization

I hereby authorize the veterinarian to examine, prescribe for and/or treat my pet(s). I understand that trained personnel will not attend to boarded or hospitalized animals beyond regular office hours.

Signature _____ **Date:** _____

****I authorize the release of my phone number, name and/or vaccine information to the Humane Society, County Officials, or individuals that have identified my animal by a rabies vaccine tag & wish to contact me to return my pet.**

Agree (initial here) _____ **Disagree (initial here)** _____

CANYON PET HOSPITAL

1054 E. Old Canyon Court * Flagstaff, AZ 86001
928-774-5197

Financial Policy

All professional fees are due at the time that services are rendered.

A deposit may be required for extensive hospitalization or emergency procedures. We accept cash, Visa, Mastercard, Discover, Care Credit and checks with proper identification and Telecheck approval. We do not accept counter or post-dated checks and will not hold checks for any period of time. There will be a \$30.00 administration fee for all returned checks.

We require a valid Drivers License and Social Security number each time we accept a check. If you would like us to keep that information on file please provide the following:

Social Security # _____

Drivers License # _____ State _____ Expiration _____

The majority of our clients regularly pay their bills when due. While in the past we have accepted an occasional delay, we are no longer able to keep services affordable without implementing a collection program to ensure payments are received on time. Monthly service fees will be added to any account balance after 30 days. Unless prior arrangements have been made, all accounts more than 60 days past due will be assigned to an outside collection agency with any collection fees being added to your account balance.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the above Financial Policy and agree to the terms.

Signature of Responsible Party: _____

Date: _____