TAYLOR CROSSING
ANIMAL HOSPITAL

Welcome!

We're very pleased that you have chosen **Taylor Crossing Animal Hospital** for your pet's care. Please complete the following information below so that we may ensure accurate record keeping and better serve you.

New Client Information

Owner's Name: _____
Street Address: _____
_____ Apt.# _____
City/State/ Zip: _____
Place Of Employment: _____
E-mail address: _____
(used only for vaccination/information reminders through Pet Portal)

Drivers License No. _____
Home Phone No. _____
Cell Phone No. _____
Work Phone No. _____
Social Security No. _____

How did you FIRST learn about us? (Check ONE box that tells how you FIRST heard of us)

- ☐ Drove by Saw Sign/Building
- ☐ Yellow Page book
- ☐ Website
- ☐ Humane Shelter
- ☐ Internet Directory Search
- ☐ Magazine Advertisement
- ☐ AAHA-Web Referral
- ☐ Returning Former Client
- ☐ Other _____
- ☐ Referred by friend, relative or organization (NAME):

Tell us *about your pet(s)…..*

Please give all previous records to receptionist to make copies

DOGS(s) Name(s)	Breed	Color	Age/DOB	Sex	Altered?
CAT(s) Name(s)	**Breed**	**Color**	**Age/DOB**	**Sex**	**Altered?**

Is your pet experiencing problems with……

☐ vomiting ☐ diarrhea ☐ sneezing ☐ coughing ☐ ears ☐ eyes ☐ itching
☐ limping ☐ seizues ☐ urinary ☐ heart ☐ behavior ☐ Other _____

Payment information: (Please check type of payment and sign statement below)
☐ Cash ☐Check ☐ Visa ☐ Mastercard ☐ Discovercard ☐ American Express ☐ Care Credit

The following people have access to my account and can authorize additional pets, products, or changes to placed on my account.

Spouse / Significant Other _____ Children _____

Other _____

I UNDERSTAND THAT ALL FEES MUST BE PAID AT THE TIME SERVICES ARE RENDERED. IN THE EVENT THE ACCOUNT IS TURNED OVER FOR COLLECTION, I AGREE TO PAY COLLECTION FEES. IN THE EVENT ANY CHECK IS RETURNED I WILL BE RESPONSIBLE FOR THE CHECK AND ALL SERVICE FEES AND RELATED EXPENSES PERMITTED BY LAW.

Client Signature: _____ Date: _____