**Ark Animal Hospital**

OFFICE USE ONLY

Info Confirmed \_\_\_\_\_\_ Entered \_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_New Client Form**

Welcome To Ark Animal Hospital

Dr. Scott Thorne

4171 Swingle Rd, Casper, WY

(307)234-1260

**Client Information**

First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I.\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouses Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Adress\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your Mailing address the same as your Physical address? Yes\_\_\_\_\_ No\_\_\_\_\_

If No, please list mailing address below

Mailing Adress\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_

Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouses Phone (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Adress\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Employment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following information is confidential and used to verify identity. In order to prescribe and release medications as deemed necessary by the Doctor of Veterinary Medicine, federal DEA laws and regulations require us to obtain both drivers license number and social security number. If you are uncomfortable writing this information, please let our staff know and you can give this information audibly.

**Drivers License: State and Number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Social Security** \_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

**DOB**\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

**Payment Agreement:** Payment is expected at time of services. For your convenience, we accept MasterCard, Visa, American Express, Discover, Cash or Check. We also accept CareCredit and Scratch Pay as a form of payment. In the event I, the owner, fail to pay for services rendered, I, the owner, agree to set up a monthly payment plan that is subjected to a monthly financing charger of 1.5% (18% APR) added onto the past due amount. If no payments have been made in within 120 days of services or last payment, your information will be sent to a collection agency or small claims court. I, the owner, hereby understand that by signing this legal document, my information may be used to collect upon a future balance owned to Ark Animal Hospital.

**Please initial that you have read and agree to the Payment agreement. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please See Reverse Side**

**Pet Information**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday / Age\_\_\_\_\_\_\_\_\_\_\_\_\_Species\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Color\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male Female Spayed Neutered

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday / Age\_\_\_\_\_\_\_\_\_\_\_\_\_Species\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Color\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male Female Spayed Neutered

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday / Age\_\_\_\_\_\_\_\_\_\_\_\_\_Species\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Color\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male Female Spayed Neutered

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday / Age\_\_\_\_\_\_\_\_\_\_\_\_\_Species\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Color\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male Female Spayed Neutered

\*\*\* If you are transferring from another veterinary clinic, by signing this form you, the owner, are giving Ark Animal Hospital permission to contact your pervious veterinary hospital to obtain medical records for the pet(s) mentioned above.

**Authorization:** I, the owner, hereby authorize Ark Animal Hospital, doctors and staff, to examine, prescribe for, or treat the above-described pet(s). I, the owner, assume responsibility for all charges incurred in the care of the animal(s). All persons listed on this form will be included on the medical record, and are authorized to make medical decisions for the listed above pet(s). I, the owner, also acknowledge that all charges incurred with the treatment of my pet(s) is due at the time of services.

Signature

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_