**Wayne Animal Hospital**

**New Client/Patient Information**

Payment in full is required at time of service. We accept cash, Visa, Master card, Discover, American Express, Care Credit, and personal checks.

**RESPONSIBLE PARTY INFORMATION:** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drivers License #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT (S) INFORMATION:**

#1 Name of Pet\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Species\_\_\_\_\_\_\_\_\_\_\_\_Breed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Color\_\_\_\_\_\_\_\_\_

Date of Birth(if known)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_ Sex\_\_\_\_\_\_ Spayed or Neutered\_\_\_\_\_\_\_\_\_\_

Does your pet have a microchip? \_\_\_\_\_\_\_ What kind of food do you feed your pet\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pet obtained from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#2 Name of Pet\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Species\_\_\_\_\_\_\_\_\_\_\_\_ Breed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Color\_\_\_\_\_\_\_\_\_

Date of Birth (if known)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_ Sex\_\_\_\_\_\_ Spayed or Neutered?\_\_\_\_\_\_\_\_\_\_

Does your pet have a microchip? \_\_\_\_\_\_\_What kind of food do you feed your pet\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pet obtained from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check any symptoms or problems that you have noticed about your pet(s)**

**PATIENT #1** \_\_Arthritis \_\_Bad breath \_\_Behavior problems \_\_Bleeding gums \_\_Blood in urine/stool \_\_Breathing problems\_\_ Changes in environment \_\_Coughing \_\_Diarrhea/constipation \_\_Excessive chewing \_\_Eye bulging or bloodshot\_\_ Gagging \_\_Lack of appetite \_\_Limping \_\_Loss of balance \_\_Mass or lump \_\_Housetraining issues \_\_Scooting\_\_ Scratching \_\_Seems depressed \_\_Shaking head \_\_Sneezing \_\_Thirst and/or urination increased \_\_Vomiting\_\_ Weakness \_\_Weight problem \_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient #2**\_\_Arthritis \_\_Bad breath \_\_Behavior problems \_\_Bleeding gums \_\_Blood in urine/stool \_\_Breathing problems\_\_ Changes in environment \_\_Coughing \_\_Diarrhea/constipation \_\_Excessive chewing \_\_Eye bulging or bloodshot\_\_ Gagging \_\_Lack of appetite \_\_Limping \_\_Loss of balance \_\_Mass or lump \_\_Housetraining issues \_\_Scooting \_\_ Scratching \_\_Seems depressed \_\_Shaking head \_\_Sneezing \_\_Thirst and/or urination increased\_\_ Vomiting \_\_Weakness \_Weight problem \_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The undersigned agrees, whether he or she signs as agent or owner, that in consideration of the services to be rendered to the patient, he or she hereby individually obligates himself or herself to pay the account of the hospital in full at the time services are rendered. Should the account be referred to any attorney or collection agency for collection, the undersigned agrees to pay all attorney’s fees and collection expenses. All Delinquent account shall accrue interest at the rate of 1.5% per month (18% APY). Thank You!**

**Signature of owner or agent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_**