



Homestead Animal Hospital New Client Form

Client Information

Name _____ Spouse/Partner _____
Address _____
Street City State Zip
Email Address _____
Phone #: Home _____ Work _____ Cell _____
Employer _____ Address _____
Drivers License # _____ SSN#: _____
Who can we thank for referring you? _____

Pet Information

Pet # 1

Name _____ Breed _____ Sex _____ Spay/Neuter? _____
Age/Birthdate _____ Color _____ Microchip # _____
Previous Vet _____ Phone # _____
Last Vaccination Date? _____
Reason for visit _____

Pet # 2

Name _____ Breed _____ Sex _____ Spay/Neuter? _____
Age/Birthdate _____ Color _____ Microchip # _____
Previous Vet _____ Phone # _____
Last Vaccination Date? _____
Reason for visit _____

We take pride in the quality of service and medical care we provide to you and your pet(s). In an effort to maintain these standards and to keep your costs at a reasonable level, we require payment in full for services at the time of treatment. We do offer Wellness Packages, which are designed to save you money as we work together to provide the best care for your pet(s). Any staff member will be happy to help you select the best plan for your pet(s).

Preferred Payment Method: Cash ____ Visa ____ M/C ____ Discover ____ AmEx ____

Check Policy: Personal checks will be accepted after your initial visit, provided we have a copy of your Florida Drivers License or other state issued identification on file.

There will be a \$30.00 minimum charge for returned checks.

I agree to pay for all professional services and medications as they are provide to my pet. The information provided on this form is true and accurate.

Owner/Authorized Representative

Date



**Medical Records Release and Authorization for Future Use and
Disclosure of Medical Information**

I authorize the custodian of records of: _____ to disclose/release, if and when needed by another veterinary facility, all records for the above mentioned pet(s).

I understand that this authorization is voluntary and that I may refuse to sign this authorization. By signing below I represent and warrant that I am the above named pet's guardian/owner and have authority to sign this document and authorize the use or disclosure of protected records and my pet(s)' health information and that there are no claims that would prohibit or restrict my ability to authorize the use or disclosure of my pet's health information and records.

Signature of Owner

Date

Name of Owner (Print)

HAH Representative (witness)