New Client Record or Annual Update
North Central Animal Hospital

Owner: _____ Co-Owner: _____

Co-Owners relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

E-Mail Address:_____

Phone Number: _____

Co-Owner Phone number:_____

Owner Occupation: _____ Employer: _____ Work Number: _____

Co-Owner Occupation: _____ Employer: _____ Work Number:_____

Emergency Contact:_____ Emergency Phone #: _____

How did you FIRST learn of our hospital?

☐ Internet: Facebook, Twitter Craigslist, Google, Other Search Engine: _____,

☐ Store: Animal Kingdom/Puppies 'n Love, Petco, Birdz And Beyond, Other:_____

☐ Other: Hospital Sign, AZ Humane Society, Maricopa Animal Care & Control, Other:_____ _

☐ Event:_____ ☐ Other Vet/Hospital:_____

Referred by:_____

Consent for Exam, Treatment, and/or Surgery:

I am the owner or agent for the owner of the described animal(s) and have authority to execute this consent. I request that North Central Animal Hospital's doctors and staff perform the services which are necessary for the examination and medical treatment of the animal(s) and to administer medical treatment or emergency care which is considered therapeutically and/or diagnostically necessary on the basis of the examination findings. I, _____ , therefore, hereby consent to and authorize the performance of such procedures as deemed necessary and desirable in the veterinarian's professional judgment. I also consent to the release of medical information. No warranty or guarantee has been made as to the result or cure. I understand that a written estimate for charges will be provided. I grant North Central Animal Hospital permission to post my pet's picture, story and medical information on social media for fun and educational reasons. We do not include client name or information.

I am 18 years of age or older, and assume financial responsibility for all charges incurred to the patient for services rendered and understand that full payment is required upon request. A monthly service charge of $7 will be added to all accounts that exceed 30 days past due. I agree to pay all attorney's fees, interest, collection costs and other costs of litigation incurred in the collection of past due accounts. A $25 returned check fee will be charged. Professional fees are due at the time services are rendered.

Please indicate your method of payment:

☐ Cash ☐ Care Credit ☐ Debit ☐ MC/Visa/Discover/Amex

☐ Check (In state, personal checks, no 3rd party): Driver's License Number: _____

Exp: _____ State: __

Signature of Owner/Agent: _____ Date: _____

(Owner or Agent must be over 18 years of age)

If Authorized Agent, Name: _____ Relationship to Owner: _____

Address of Agent: _____ Phone #: _____

Employee initial __

Please email completed form to: NorthCentralReceptionists@gmail.com