New Patient Form

Client Information

Name of Owner ____

Name of Other Interested Party *(Spouse/Parent)* ____

Address____

City____

State ____Zip________________________

Home Phone_________________ Work Phone_________________ Cell_________________

Email Address____

Patient Information

Name ____

Birth Date/Age ____________________ Species ☐ Dog ☐ Cat ☐ Other _____________

Breed ____Color ______________

Sex ☐ M ☐ F Spay/Neuter ☐ Y ☐ N ☐ Unknown

Reason for Visit ____

Method of Payment

☐ Cash ☐ Check ☐ VISA/MC ☐ Discover ☐ AMEX ☐ Care Credit

Payment is due at the time service is rendered. No billing is offered.

I hereby grant, to the veterinarian(s) in charge of the care of the patient described above, the authority to examine said patient in order to determine a course of treatment that he/she believes to be in the best interest of the patient. By agreeing to this examination, I consent to pay the fee associated with said examination. I also understand that any further treatments, testing or procedures deemed necessary or advised will be performed only after I have granted permission. My signature indicates that I am personally responsible for and will pay all charges incurred and I understand and will comply with Seaside Veterinary Hospital policy that requires payment in full at the time of service.

Date______________Signature ____

If you are transferring from another vet, please provide their name and number______________

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