

WKVH New Client Form

Thank you for giving us the opportunity to care for your pet(s). So that we may become better acquainted, please complete the following:

OWNER INFORMATION

Last Name	First Name	Date
Street Address		Apt/Unit #
City:	State: SC	Zip:
Primary Phone	Work Phone(s)	Other Phone(s)
Co-Owner Name Last	Co-Owner Name First	Primary Phone
Email	Address	
How did you hear about us?	Personal Reference	Who may we thank?

How did you become aware of our Hospital? Drove by Coupon Billboard Website / Internet

All Fees Are Due At the Time Services Are Rendered.



We Accept: Visa, MasterCard, Care Credit, Checks and Cash



PET INFO

	PET # 1	PET # 2	PET # 3	PET # 4
Name				
Age/DOB <small>(or best estimate)</small>				
Species <small>(Please Specify)</small>	<input type="checkbox"/> Dog <input type="checkbox"/> Cat	<input type="checkbox"/> Dog <input type="checkbox"/> Cat	<input type="checkbox"/> Dog <input type="checkbox"/> Cat	<input type="checkbox"/> Dog <input type="checkbox"/> Cat
Breed				
Color				
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Neutered <input type="checkbox"/> Female <input type="checkbox"/> Spayed	<input type="checkbox"/> Male <input type="checkbox"/> Neutered <input type="checkbox"/> Female <input type="checkbox"/> Spayed	<input type="checkbox"/> Male <input type="checkbox"/> Neutered <input type="checkbox"/> Female <input type="checkbox"/> Spayed	<input type="checkbox"/> Male <input type="checkbox"/> Neutered <input type="checkbox"/> Female <input type="checkbox"/> Spayed

I assume responsibility for all charges incurred in the care of this / these animal(s). I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment or hospitalization. Should my account become delinquent, I assume responsibility for all collection fees in addition to the amount of my bill. I am aware that the practice of medicine and other health care professions is not an exact science and I further state and understand that no guarantee has been or can be made as to the result of treatments or examination at WKVH

Owner or Responsible Party Signature

Please print your name