Welcome To Our Clinic
Stonecrest Animal Hospital
New Client Information Form

Name:_____
Last **First** **Spouse**
Address:_____
Street **City, State, Zip Code**

Social Security No _____

Phone Number:_____**Cell Phone:**_____

Work Phone_____**Employer**_____

Email Address:_____

How did you hear about us?_____

***Pet (1) Name*:**_____

Birthdate_____ **Species: _____ Canine _____Feline**

Breed:_____ **Sex: ____Male ____Female**

Spayed or Neutered?:_____ **Color**_____

***Pet (2) Name*:**_____

Birthdate_____ **Species: _____ Canine _____Feline**

Breed:_____ **Sex: ____Male ____Female**

Spayed or Neutered?:_____ **Color**_____

I understand that payment is expected at the time services are rendered. I assume all responsibility for charges that are occurred during treatment of the above named pet(s). Failure to pay these charges may result in my account being turned over to a collection agency, thus making me also responsible for any collection fees that occur. I further understand I have the right to request a written estimate if I so choose and may discuss any and all fees prior to treatment.

Method of payment: Cash MasterCard Visa Discover AMEX CareCredit

Signature:_____**Printed Name:**_____