SCISSORTAIL
VETERINARY SPECIALISTS

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NEW PATIENT FORM

CLIENT INFORMATION

Client Name(s) (First & Last): _____

Address: _____
(Street) (City) (State) (Zip Code)

Primary Phone: _____ (☐ Mobile ☐ Landline) **Who's Number:** _____

Alt Phone: _____ (☐ Mobile ☐ Landline) **Client E-mail:** _____

Have any of your pets been here in the past? ☐ **Yes** ☐ **No** *If Yes, list pet name(s):* _____

REFERRING VETERINARIAN INFORMATION

DVM: _____ **Hospital Name:** _____

DVM/Hospital Phone Number: _____

PET INFORMATION

Patient Name: _____ **Species:** _____

Breed: _____ **Color:** _____

Age or DOB: _____ **Weight (Kg):** _____ **Sex:** ☐ **Male** ☐ **Male Neutered** ☐ **Female** ☐ **Female Spayed**

Is your pet aggressive or fearful during veterinary visits? ☐ **Yes** ☐ **No**

What is the primary medical concern for your pet? _____
_____
_____
_____

AUTHORIZATIONS

Do you consent for pictures of your pet and/or their procedure to be used in veterinary educational material, on-line social media, or our website? ☐ **Yes** ☐ **No**

I hereby authorize Scissortail Veterinary Specialists to examine, prescribe for, and/or treat the above described pet. I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges must be paid at the time of discharge and that a pre-payment will be required for all surgical procedures and treatments.

Accepted forms of payment include debit card, Mastercard, Visa, Discover, and Care Credit. Should this account default and is referred to an attorney for collection, then I agree to pay all collection costs, including attorney fees up to 40% of the principal amount due and owing when turned over for collection. I also agree to pay interest on the unpaid balance at the rate of 1.5% per month (18% per annum) from the date that said monies become due and payable.

Client Signature: _____ **Date:** _____

"Created to serve, trained to heal."