Welcome to.....

THE ESSEX ANIMAL HOSPITAL

New Client/Patient Information

OwnerName: _____Spouse/Partner/Other: _____

Address_____City:_____State:_____Zip:_____

Email (Owner):_____Email (Other):_____

Essex Animal Hospital requests your email address for the sole purpose of hospital-client communication. We will not sell or utilize your email address for any other purpose.

Phone Number:	**Owner**:	**Spouse/Partner/Other**
Home Contact Number:	(_____) _____-_____	(____) _____-_____
Cell Contact Number:	(_____) _____-_____	(____) _____-_____
Work Contact Number:	(_____) _____-_____	(____) _____-_____

We accept the following forms of payment: MasterCard, Visa, AMEX, Discover, Debit Cards, Checks and Cash
If paying by **CHECK** please provide the following:

Social Security #_____-_____-_____ Driver's Lic #_____EXP_____

In addition to the owner listed above, the following adults (age 21 or older) are authorized to make medical And/Or financial decision concerning my pet's care.
Spouse/Partner/Other (as listed above) Yes _____ No _____
Other adults (not listed above) _____

How did you hear about Essex Animal Hospital? Yellow Pages/ Phone Directory_____
Passed By/Sign. _____ Internet/Website _____
Personal recommendation (who may we thank?) _____

******PET INFORMATION******

Name_____ Species (dog, cat other)_____

Gender (Please Circle) Male/Female Neuter/Spayed Breed_____

Birth Date (If known) _____ Color /Markings _____

PAYMENT IS DUE IN FULL AT THE TIME SERVICES ARE RENDERED. A DEPOSIT WILL BE REQUIRED FOR ALL ADMITTED PATIENTS INTO THE HOSPITAL. UPON REQUEST, AN ESTIMATE CAN BE GIVEN BY THE DOCTOR, PRIOR TO ANY PETS RECEIVING MEDICAL TREATMENT IN OFFICE OR FOR HOSPITALIZATION.

As owner of the above pet, I agree to pay all fees for services rendered in the care of my pet at the time my pet at the time my pet is discharged, regardless of who has authorized these charges. If requested, I will be provided an estimate for services.

Signature: _____ Date: _____