

## CLIENT INFORMATION

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

E-mail: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Alternate Contact: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Cell \_\_\_\_\_ Alternate \_\_\_\_\_  
Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Driver License/ID# \_\_\_\_\_ Date of Birth \_\_\_\_\_

### ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED

Please indicate choice of payment:

Cash    Visa    Mastercard    Discover    American Express    Care Credit    Scratchpay

How did you become aware of our clinic?

Drove by Yellow Pages    Google    Previous Client    Referral    Other

Do You have pet Insurance? YES    NO    What Insurance Company are you with? \_\_\_\_\_

### PET(S) INFORMATION

List all your Pets	Pet #1	Pet #2	Pet #3
NAME OF PET			
SPECIES(K9 or Feline)			
BREED OF PET			
COLOR OF PET			
DATE OF BIRTH			
MALE OR FEMALE			
NEUTER OR SPAYED			

Has your pet had any previous illnesses or surgeries? \_\_\_\_\_

Is your pet allergic to any medications or vaccines?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Owner or Responsible Party: \_\_\_\_\_ Date \_\_\_\_\_

Print Name: \_\_\_\_\_

# Alameda Animal Hospital

925 S. Alameda St.  
Compton, Ca 90220  
310-638-4149

## Our Financial Policy

Thank you for choosing Alameda Animal Hospital as your Veterinary Healthcare Provider. We are committed to your pet's treatment being successful. The following is a statement of our Financial Policy, which we require you to read, agree to, and sign prior to any treatment.

- All clients must complete our "Client Information Sheet" before seeing the doctor
- Full payment is due at time of service
- We accept Cash, Visa, MasterCard, Discover, American Express, and Care Credit
- A deposit may be required for any procedure

## Regarding Insurance

We do not accept insurance. As a courtesy, however, we will help you receive maximum benefits by filling out insurance claim forms for your reimbursements.

## Usual and Customary Rates

Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. You are responsible to pay the bill in full regardless of the insurance company's determination of usual and customary rates.

## Medical Records

To give our doctor a better understanding on the pet's history, we would like to get records from your pet's previous veterinary hospital. Please fill out the hospital name and number to help us provide the necessary records.

Hospital: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## Patient Photos

Do you allow Alameda Animal Hospital to upload and display your pet(s) photo onto our Facebook page, website and/or media outlets? If **Yes**, please sign below

X \_\_\_\_\_

**\*All patient photos may or may not display your pet's name. No other information will be displayed\***

**I have read, understood, and agree to the above Financial Policy.**

Signature of Owner \_\_\_\_\_

Or Responsible Party X \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_