

Client In-take

Client Name	Client Name (Co-Owner)
Phone Number	Phone Number (Co-Owner)
Email Address	Email Address (Co-Owner)
Primary Address	

Patient Information

Patient Name	Date of Birth	Color/Markings
Breed	sex: Male <input type="checkbox"/> neutered <input type="checkbox"/> Female <input type="checkbox"/> spayed <input type="checkbox"/>	

Basic Information

Does your pet have a microchip? Y / N **If so, then please provide the ID #** _____

Typical Food: (i.e brand, variety, wet, dry, etc.) _____

Which fits your pet living arrangement: indoor outdoor both

Medical Information

Special Medical History: _____
 Please bring any and all of your pet's previous medical records to your visit.

Does you pet have any known allergies or reactions to medication or food? yes / no

If you answer "yes", please specifiy: _____

Is your pet up to date on vaccines? yes / no

Is your pet on heartworm prevention? yes / no **brand name:** _____

Is your pet on flea and tick prevention? yes / no **brand name:** _____

Are you coming from a different doctor or hospital? yes / no

If yes, please provide the doctor or hospital: _____

Getting to know your Pet



How would you describe your pet's reaction to going to the vet?



**Is your pet on any chronic medication/supplements?
Please list the names and brands**



Are there any veterinary procedures that made your pet particularly uncomfortable in the past or that seemed difficult for you or the staff to do? (nail trim, blood work, temperature check, ear exam, etc.)



Are there any special instructions related to your pet that would like us to know?



Recurring Credit Card Payment Authorization

You authorize regularly scheduled charges to your credit card. You will be charged the amount indicated below each billing period. A receipt for each payment will be provided to you and the charge will appear on your credit card statement. You agree that no prior notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I _____ authorize **Happy Tails Veterinary Hospital** to charge my
(Cardholder's Name)

Credit Card indicated below for \$ _____ on the _____ of
(Amount \$) (day)
each _____.
(week, month, etc.)

Billing Information

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

Card Details

Visa MasterCard Discover American Express

Cardholder Name _____

Account/CC Number _____

Expiration Date ____ / ____

CVV _____

Zip Code _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify **Happy Tails Veterinary Hospital** in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____
(Cardholder's Signature)

DATE _____



24 Hour Cancellation & “No Show” Fee Policy

Recognizing that everyone’s time is valuable and the appointment time is limited, we ask that you provide a 24 hour notice if you are unable to keep your appointment. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Happy Tails Veterinary Hospital, in Pasadena, MD reserves the right to charge a fee of \$25.00 for each missed appointment if it is not canceled with 24 hours advanced notice. If it your first appointment with Happy Tail as a new patient, that was missed without 24 hour advance notice, the fee will be \$65.00 (the exam fee).

“No Show” fees will be billed to the patient. This fee is not covered by pet insurance or the Wellness Plan, and must be paid prior to your next appointment. Multiple “No Shows” in any 12 month period will result in termination from our practice.

Thank you for you anticipated cooperation.

By signing below, you acknowledge that you have received this notice and understand this policy

Printed, Last Name, First

Date

Signature



Please include you favorite picture of your pet. Their photo will be linked to there medical records.

PET PHOTO CONSENT FORM

I, _____, hereby grant _____ permission to use any photographs taken of myself or my pet, in any and all of its publications, including website entries, without payment or any other consideration. I understand and agree that these materials will become your property and will not be returned. I hereby authorize to edit, alter, copy, exhibit, publish or distribute this photo for purposes of publicizing your programs or for any other lawful purpose.

In addition, I waive any right to royalties or other compensation arising or related to the use of the photograph. I hereby release rights to all claims, demands, and causes to action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf of my estate have or may have by reason of this authorization. In signing this consent, I give authorization to use my name and my pet's name and information as printed below.

(Pet's printed name)

(Owner's Signature)

(Date)

(Owner's printed name)