New Client & Patient Form

Clinic Policy: Payment is due to be paid in full at time services are rendered.
For delayed payment options, we offer Care Credit.
*We accept all major credit
cards, cash, & debit cards

The information provided is accurate to the best of my knowledge. I hereby authorize Collingswood Veterinary Hospital to provide medical care/treatment for my listed pet(s) from this date forward and I understand the payment policy.

X_____X_____
Signature DATE

I authorize Collingswood Veterinary Hospital to take photos of my pet(s) and use for any lawful purpose, including, publicity purposes, illustration, advertising, and web/social media content.

X_____X_____
Signature DATE

Client Name: _____ Spouse's Name: _____
Address: _____ City: _____ Zip: _____
Home_____
Phone_____
Cell Phone: _____ Other: _____
Email Address (Please provide an email Address for Reminders):
_____@_____._____

Patient Name: _____
Species: Feline/ Canine
Breed: _____
Sex: Male/Female Spayed/Neutered
Age/D.O.B.: _____
Markings: _____
Color: _____ Current Diet (Food Brand): _____
Please list below a past/current medical problems or known sensitives to medications, vaccinations, or food. Also list current medications, including heartworm or flea/tick control:

_____
_____
_____
_____

***For the safety of our staff and clients, please alert us if your pet is people aggressive, or has bitten any person.**

Is anyone else other than yourself authorized to make medical decisions or approve treatments for your pet(s)? If Yes Name: _____ Phone: _____

medical decisions or approve treatments for your pet(s)? If Yes

Name: _____ Phone: _____