



Circle City Veterinary Specialty & Emergency Hospital

9650 Mayflower Park Drive, Carmel, IN 46032
(317) 872-VETS (8387)
www.circlecityvets.com

New Client Information

In order for us to serve you properly, please take the time to complete this questionnaire and bring it with you to the initial examination. Please have your primary veterinarian fax your pet's detailed records to us at (317) 872-1964. All information is held strictly confidential.

PLEASE READ BEFORE SIGNING:

I understand that I am responsible for all charges at the time services are rendered. Forms of payment accepted are MasterCard, Visa, CareCredit, personal check, or cash. All balances unpaid after 30 days will be charged 1.5% interest per month. I am also responsible for any fees for collection or attorney fees regarding any unpaid balance. There is a \$25 charge on all returned checks. I understand to write a check to the Circle City Veterinary Specialty & Emergency Hospital, I must present a driver's license or state identification.

Any appointment cancellation must be made 24 hours prior to the appointment or an office call will be charged to my account.

I understand my pet's records are confidential and give permission for them to be shared with the hospitals/veterinarians identified on this form and/or any noted in the record itself.

SIGNED

DATE

PLEASE PRINT ALL INFORMATION

OWNER'S NAME

Last First CELL PHONE _____
WORK PHONE _____

CO-OWNER OR SPOUSE

Last First CELL PHONE _____
WORK PHONE _____

HOME PHONE NUMBER: (____) _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL ADDRESS _____

Please continue on back

Please tell us how you discovered our hospital:

- Phone book
- On the Internet
- Driving by location (sign)
- Veterinarian
- Friend: let us know so we can thank them _____
- Other: please explain _____

Pet's Name: _____ Canine or Feline (circle one)

Breed: _____ Color: _____

Birth Date or approx age: _____

Sex: _____ Neutered or Spayed (circle one)

Approximate age when neutered/spayed _____

Current veterinarian and/or hospital:

Previous veterinarian/hospital: _____

Date of last vaccination: _____ Type of vaccinations given: _____

Has your pet had any previous medical problems other than the present condition?
(If yes, briefly describe. Also include any surgical procedures other than routine dentals.)

Does patient have known allergies to drugs or other specific materials? Please list.

Has patient regularly taken medication for something other than heartworm preventative or flea control?

<u>Name of medication</u>	<u>Used for</u>	<u>Started</u>	<u>Last used</u>
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