New Client Information

ACCESS Specialty Animal Hospitals®

Internal Use Only Account #: _____ Patient #: _____

Please complete all questions below.

- Owner's Full Name: _____

Tel: (Primary) _____ Tel: (Secondary) _____

Email Address: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Date of Birth of Owner: Month / Day / Year _____

The DEA requires the date of birth of pet owners in order for medications to be dispensed.

- **Authorized Agent:** Do you have someone who can be contacted to authorize treatment changes if you are unreachable? Yes ☐ No ☐

Name of other Authorized Agent: _____

Tel: (Primary) _____ Tel: (Secondary) _____

- **Primary Veterinarian(s):** _____ Primary Hospital / Practice: _____

Other veterinarians or specialty animal hospitals your pet has been treated by? _____

- **Name of Pet:** _____ Breed: _____ Color: _____

Species: Dog ☐ Cat ☐ Bird ☐ Small Mammal ☐ Reptile ☐ Other ☐ _____

Male ☐ Female ☐ Spayed / Neutered: Yes ☐ No ☐ Unsure ☐ _____

Approximate Age / Date of Birth of your pet: _____

Medications your pet is currently taking: _____

- Have you visited ACCESS Specialty Hospitals in the past? Yes ☐ No ☐ Location: _____

How did you hear about ACCESS Specialty Animal Hospitals? _____

- *I authorize and direct the veterinarians at ACCESS Specialty Animal Hospital to diagnose, prescribe medications (recognizing that some medications used may be off-label), perform therapeutic procedures and/or surgery that their judgment may dictate to be advisable for the well-being of the patient. I also understand that no warranty or guarantee has been made as to the result or cure, and that I am financially responsible for authorized services performed.*

Please Print Name _____

Client or Authorized Agent Signature _____ *Date* _____