NEW CLIENT FORM

Welcome to Four Paws Animal Hospital & Wellness Center. Thank you for giving us the opportunity to care for your pet. Please help us meet your needs better by taking a moment to complete this information sheet.

It is our policy to protect your privacy. This information will not be sold or provided to any third party without your permission.

PRIMARY CONTACT INFORMATION

NAME

MR. MRS. DR. _____

FIRST | LAST | OTHER

MAILING ADDRESS

STREET | SUITE/APT # | COUNTY

❑ Fredericksburg ❑ VA

CITY | STATE | ZIP

If your physical/residential address is different than your mailing address, please provide that as well. Otherwise write "same."

TELEPHONE *Please write 1, 2, or 3 next to home/work/cell to indicate your order of preference.*

HOME | WORK | CELL

EMAIL *By providing your email address, you consent to receive reminders and alerts by email*

EMAIL ADDRESS

DRIVERS LICENSE *Must be provided in order to write checks*

❑ VA

LICENSE NUMBER | EXPIRATION DATE | ISSUING STATE

WORK ADDRESS

EMPLOYER | STREET

❑ VA

CITY | STATE | ZIP

ALTERNATE CONTACT INFORMATION

You may authorize another person to make decisions about your pet's care. This person must be at least 18 years of age. This authorization does not relinquish your financial responsibility for charges incurred on your behalf.

NAME

MR. MRS. DR. _____ (OTHER)

FIRST LAST

TELEPHONE

HOME WORK CELL

PET SURVEY INFORMATION

Please indicate how important your pet(s) are to your family:

☐ Very important ☐ Important ☐ Somewhat important

HOW DID YOU HEAR ABOUT US?

☐ Newsletter ☐ Road/Building Sign ☐ Phone Book ☐ YMCA ☐ Flyer/Mailer

☐ Fredericksburg Field House ☐ Website / Internet ☐ American Family Fitness ☐ Welcome to the Neighborhood postcard

REFERRED BY ________________________ OTHER ________________________

CLIENT REFERRAL PROGRAM

If you were referred to us by a current client of ours, you will both receive a reward. Please indicate the name of the person who referred you in the box above. Ask a staff member for further details about the program.

PAYMENT POLICY

Payment is due at the time services are rendered. We accept cash, checks drawn from a local bank, Visa, MasterCard, and Care Credit. There will be a $40 fee for returned checks that are not recovered through Federal Automated Recovery Systems. In the event this account shall be in default and placed with a collection agency for collection, then the undersigned agree to pay all reasonable costs of collection and twenty-five percent for attorney's fees.

Signature Date