Fort Payne Animal Hospital
New Patient Form

Owner Information

Owner's Name: _____ Secondary Contact Name and # _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

E-mail Address: _____ Preferred Method of Contact: _____

Driver's License No. _____ Employer/Occupation: _____

How did you hear about us? ☐Social Media ☐Drive by ☐Times Journal ☐Friend:_____

***Areas that are highlighted are required. A copy of the owner's drivers license is also required. We use your email to notify you of appointment or vaccine reminders. All information is secured and will not be shared.

Patient Information

1. Patient's Name: _____ Species: _____ Breed: _____

DOB: _____ Color: _____ Sex: _____ ☐Spayed ☐Neutered

2. Patient's Name: _____ Species: _____ Breed: _____

DOB: _____ Color: _____ Sex: _____ ☐Spayed ☐Neutered

Does your pet have a microchip? ☐Yes ☐No

Patient Medical History

Specific Medical History: _____

Does your pet(s)have any known allergies or reactions to any medication or food? ☐Yes ☐No

If you answered "Yes" above, please elaborate here: _____

Is your pet(s) up-to-date on vaccinations? ☐Yes ☐No

Is your pet(s) on: ☐Flea and Tick Preventative ☐ Heartworm Preventative

Are you coming from a different doctor or hospital? ☐Yes ☐No

If "Yes", name of Doctor/Hospital: _____

Financial Statement: Payment is due at the time of service rendered. Payment can be made in the form of cash, check, debit card, or credit card. At your request, we are happy to provide an estimate for services. If we proceed to collectors for any account past due the client is responsible for all costs including attorney fees. A $10 late charge will be added to all accounts in default at the end of each month. The client will be responsible for all fees incurred or any returned checks.

Signature: _____ Date: _____