Cross River Animal Hospital

810 Route 35, Cross River, NY. 10518 *Phone: (914) 763-8121 *Fax: (914)763-9325

New Client Information

Please Print

Owner name: _____ Spouse / Partner: _____

Address: _____ City & State: _____ Zip: _____

Home phone: (_____)_____ Cell phone: (_____)_____

***E-mail**_____

What most influenced your decision to choose our hospital?

Phone Book Internet Location Other: _____

Client Referral ** **Who? So we may thank them: _____

Preferred method of payment**:** Cash MasterCard Visa

Credit Card # _____ Exp. Date: _____ Security Code_____

Driver's License # _____ State: _____ D.O.B. _____

*Please subscribe me to the **FREE** Pet Living & Wellness Newsletter: ☐ **Yes** ☐ No

Topics of Interest: ☐Dogs ☐Cats ☐Dr/Member Announcements.

New Patient Information

Pet's name: _____ D.O.B. _____

Please circle: Canine Feline Male Female Neutered Spayed

Breed: _____ Color: _____

Health history: (e.g. allergies, chronic ear infections) _____

Is dog tattooed / microchip? Yes No If yes, # _____ Is cat declawed? Yes No

Name of last veterinarian hospital: _____ Phone: (___)_____

Payment in full is required when services are rendered on non-hospitalized patients.
If your pet needs to be hospitalized or is having surgery, an estimate for cost of services will be provided.
A 50% deposit of the estimate will be required at that time.
All fees must be paid in full when your pet is discharged from the hospital.

I authorize and acknowledge financial responsibility for veterinary/boarding/surgical/grooming services rendered by the Cross River Animal Hospital. I understand that I am responsible to pay for uncollected fees, accrued interest, postal fees and expenses incurred by attorneys, collection agencies and/or medical and clerical research time due to non-payment. I also authorize the use of my credit card on file to pay for services rendered and any unpaid balances. I am the owner/agent of the above named pet and am responsible for it. I also have the authority to execute this consent and am 18 years of age or older.

Signature: _____ Patient #: _____

Date: _____