Patient ID #: _____

1238 NH Route 11 P.O. Box 725 Farmington, NH 03835
Phone: 603-755-9004 Fax: 888-550-1584 Email: cochecovet@cochecovet.com

PATIENT AND CLIENT INFORMATION SHEET

CLIENT INFORMATION: **Date:_____**

Owner(s):_____
Last First MI

Billing Address:_____

City/State/Zip_____

Phone: Home _____ Cell _____ Alt phone _____

Email Address: _____

Employer: _____Address: _____

Previous Veterinarian: _____Practice/Hospital:_____

Phone: _____ Address: _____

PATIENT INFORMATION:

Patient's Full Name: _____ DOB/Age: _____ Breed: _____

Sex: _____ Spayed/Neutered: Yes or No Color: _____ Microchip#: _____

Present Feed Schedule (Please list brand, quantity, and frequency):_____

Pre-Existing Health Condition(s): _____

Supplies Left: _____(Please leave as few supplies as possible)
(Please note: We will not be held responsible for any personal belongings left at the hospital)

Is Patient Insured? _____ If yes, Company:

_____

Surgical Insurance? _____ Mortality Insurance?

_____

(Please inform your insurance company that your animal has been admitted. We will complete the necessary forms when received, and your insurance company will reimburse you for your payment to Cocheco Veterinary Hospital.)

TREATMENT:

I am the owner of the above named animal or am responsible for it and have the authority to execute this consent. I hereby authorize the performance of the following procedure(s):

_____

_____

_____

MEDIA RELEASE: (optional)

I, owner/agent, hereby authorize Cocheco Veterinary Hospital to use, reproduce, and/or publish audio, photos, diagnostic images, and video, that may pertain to my animal without compensation. I understand that this material may be used in various publications, updates to my referring veterinarian, and lectures for educational purposes. This material may also appear on the CVH or sponsor's Internet web page. This authorization is continuous and may only be withdrawn by my specific rescission of this authorization. CVH or sponsors may publish materials without using my name or my animal's name in any manner CVH deems appropriate to promote and/or publicize service opportunities.
□ YES □ NO

_____
*Initials

RABIES STATEMENT: (Please fill out the rabies statement only if your pet is getting a rabies vaccine today)

I swear that, to my knowledge,_____ has not bitten anyone within the last 10 days.

(Signature)_____Date:_____

PAYMENT POLICY:

CASH, CHECK, OR CREDIT CARD DEPOSIT OF LOWER END OF ESTIMATE IS REQUIRED UPON ADMITTANCE. FULL PAYMENT IS REQUIRED UPON DISCHARGE.
Please indicate your choice of payment below:
□ Cash
□ Check: #_____ Drivers License State and #: _____
A $30.00 service charge will be assessed for any returned check. We will not redeposit the check; your credit card will be charged for the outstanding balance.

□ Credit Card (Type): _____ Card #: _____Exp. Date: _____Vcode:_____
Cardholders Name: _____Billing Zip Code (of Card): _____

Client agrees that payment is due upon discharge of the patient. Any unpaid balance will be charged to the credit card on file. Unpaid balances will be subject to interest at the rate of 24% per year (2% per month) until such unpaid amount is paid in full. Additionally, the client will be responsible for the reasonable cost of collection of any such unpaid amounts, including collection and attorney's fees.

_____
*Signature of Owner or Authorized Agent Date