Welcome to our practice! Thank you for giving us the opportunity to care for your pet. To ensure you and your pet receive the best care possible, please fill out this form completely. Please print neatly and avoid the use of abbreviations. Please note that you are authorizing Rainbow Animal Hospital to contact you by any means listed below.

Client Information:

Name:_____ Mailing Address: _____

City:_____ State:_____ Zip Code:_____

Main Contact Number:_____Circle: Home Cell Work Text Message: Yes No

Email Address: _____ Social Security #:_____

Employer:_____ Occupation:_____

Spouse/Sig Other Information (optional):

Name:_____ Social Security #:_____

Main Contact Number:_____Circle: Home Cell Work Text Message: Yes No

Alternate Contact Number:_____Circle: Home Cell Work Text Message: Yes No

Employer:_____ Occupation:_____

Is there anyone you would like us to contact in the event of an emergency if the above parties are unreachable?

Name:_____ Phone:_____

Please indicate how you learned about us:

____Hospital Sign/Building Location
____Google Search
____Yelp
____Bing.com
____Yahoo Search
____Personal Recommendation (Who may we thank?):_____
____Yellow Pages (Print Ad)
____Angie's List.com
____Facebook
____Other (Explain):_____

Patient Information:

Name:	_____	_____
Species:	_____	_____
Breed:	_____	_____
Sex (spayed or neutered):	_____	_____
Coat Color:	_____	_____
Birthdate/Age:	_____	_____
Microchip #:	_____	_____

Please list your pet's previous hospital _____

Please list the dates of your pet's most recent vaccinations against the following:

Canine		
Distemper (DA2PL):	_____	_____
Parvovirus:	_____	_____
Bordatella:	_____	_____
Rabies:	_____	_____
Lyme Disease:	_____	_____
Canine Influenza	_____	_____
Feline		
Distemper/Upper Resp. (FVRCP):	_____	_____
Rabies:	_____	_____
Feline Leukemia Test/Vaccination:	_____	_____

Please let us know if we have your permission to feature your pet's photo on our Facebook page: circle one (yes/no)

Rainbow Animal Hospital
Payment Policy

To follow is Rainbow Animal Hospital's standard policy regarding payment. Please read this carefully. If you have any questions, please see a customer service representative for further clarification.

- ✓ Payment in full is due at the time of service.
- ✓ A deposit of up to 100% of estimated fees may be required prior to providing medical services.
- ✓ Acceptable forms of payment include cash, debit card, Mastercard, Visa, Discover, or CareCredit. Identification will be required for all non-cash payments. Personal checks are not accepted from clients who have been established for less than 12 months or have been in for fewer than three total visits.
- ✓ Rainbow Animal Hospital does not offer any "in-house" billing. Financing is available only through Care Credit (medical credit card) with prior credit approval.
- ✓ In the event that charges should go unpaid for services rendered, the account will be turned over to an outside agency for collection. Should this occur, the responsible party will be liable for all costs incurred, including any additional collection fees (collection fees are generally 40% of the total amount owed) and/or reasonable court costs and attorney fees.

Please note that we do not accept personal checks from newly established clients.

I have read and understand Rainbow Animal Hospital's payment policy, and intend to pay today in full via:

____Cash

____Debit Card

____MasterCard

____Visa

____Discover/Novus

____CareCredit

1. I am the owner or authorized agent for the owner and am 18 years of age or older. I authorize Rainbow Animal Hospital veterinarians and healthcare team members to examine, prescribe for, or treat the pet(s) presented for care, and assume full financial responsibility for all charges incurred by said care.

2. I give Rainbow Animal Hospital permission to release my pet's medical records to another animal care facility, should they be requested.

3. I understand that Rainbow Animal Hospital team members are not present after regular business hours, and as such, my pet will not be monitored continuously throughout the night if overnight hospitalization is required. If I wish to have continuous monitoring, I will transfer my pet to an emergency hospital for critical care and overnight observation.

4. Please indicate *any* individual(s) (including your spouse or significant other) who has your consent to make changes to your account information, transfer your pet into a different owner's name, and make medical or financial decisions on your behalf. All listed individuals must be 18 years of age or older:

Name(s) _____

Client Name (Please Print)_____

Client Signature_____Date_____