Office use:
File #:_____

Layton Veterinary Hospital
NEW CLIENT FORM

Please tell us about yourself:

Are you at least 18 years of age or older ? Yes ☐ No ☐ (If No, please speak to us before completing this form)

Your name (first & last):_____ Spouse:_____

Address:_____ Apt #_____ City_____ State:_____ Zip:_____

Primary phone# : (_____)_____ Secondary phone# : (_____)_____

Emergency contact (Someone other than you) :_____ Phone: (_____)_____

E-mail address: _____ (For pet's vaccination reminders & hospital promotions. We do not share email addresses)

Employer :_____ Employer's Phone : (_____)_____

How did you hear of us ? :

Yellow Pages ☐ Shelter / Rescue ☐ Friend /Acquaintance-_____

Please tell us about the pet(s) we will be seeing today :

	First Pet:	Second Pet:	Third Pet:
Name:	_____	_____	_____
Species:	❑ Dog ❑ Cat ❑Other (fill in): _____	❑ Dog ❑ Cat ❑Other (fill in): _____	❑ Dog ❑ Cat ❑Other (fill in): _____
Sex: (mark one)	❑ Male ❑ Female ❑ Neutered Male ❑ Spayed Female	❑ Male ❑ Female ❑ Neutered Male ❑ Spayed Female	❑ Male ❑ Female ❑ Neutered Male ❑ Spayed Female
Breed:	_____	_____	_____
Color:	_____	_____	_____
Age or Birth date:	_____	_____	_____

****Many pets get lost and are identified by our rabies tags. If they never reach the animal shelter please consider the following**

*****We automatically release personal information to police, and animal control agents only. *****

I would like to authorize the release of my phone number/ address to the following people in the event that they have found one of my pets.

Initial next to those you authorize: Private Citizens -_____ Rescue Groups - _____ Veterinarians - _____

Please list any other authorized account users :

I would like to authorize the following people to make decisions regarding treatment for my pet(s), incur medical expenses, access my pet's full medical history and make payment arrangements. Furthermore, I agree to be financially responsible for fees resulting from their decisions.

Full Name:_____ Relation to you : _____

Full Name:_____ Relation to you : _____

Please read and sign below:

I understand that I am responsible for all charges incurred from medical treatment at this facility and that **payment is due at the time of service.** I also understand that I am financially responsible for all expenses incurred by myself or any of the authorized users listed on this form. If my account carries a balance to a new month, I will be assessed a 1½% finance charge (minimum of $4.50). If a monthly payment is not paid toward the balance, my account will be sent to a collection agency, and incur collection fees of 40% of the balance owed.

*****We no longer accept Personal Checks /** We do accept - CASH VISA MASTERCARD DISCOVER CARE CREDIT

Signed _____ Date _____