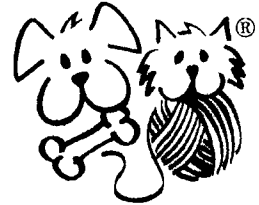


Chisholm Ridge Pet Hospital
New Client Form



Owner Name: _____
Street: _____ Apt.# _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ May we call you at work? Y / N
Spouse: _____ Cell Phone: _____
Work Phone: _____ May we call you at work? Y / N
Email: _____

1st Pet Name: _____ Dog/Cat/Other _____ DOB/Age _____
Breed/Color: _____ Male Neutered Male Female Spayed Female

2nd Pet Name: _____ Dog/Cat/Other _____ DOB/Age _____
Breed/Color: _____ Male Neutered Male Female Spayed Female

3rd Pet Name: _____ Dog/Cat/Other _____ DOB/Age _____
Breed/Color: _____ Male Neutered Male Female Spayed Female

4th Pet Name: _____ Dog/Cat/Other _____ DOB/Age _____
Breed/Color: _____ Male Neutered Male Female Spayed Female

How did you hear about us? Friend Internet Search Drive By Yellow Pages Shelter/Clinic
Please specify name of source/reference: _____

Payment Method: ___ Cash ___ Credit ___ Debit ___ Check ___ CareCredit (6 months same as cash)

Payment is due in full at the time services are rendered. Returned check fee is \$30. Any unpaid balance will be subject to a minimum billing fee of \$5 per month up to 18% (APR). Any fees incurred in attempting to collect (including collection agency fees, and court costs) will be added to outstanding balance. I have read and understand the above statements and agree to all terms therein:

Signature: _____ Date: _____