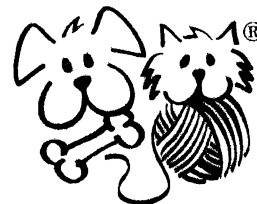


Chisholm Ridge Pet Hospital
New Patient Information



Owner Name: _____
Street: _____ Apt#: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ May we call you at work? Yes No
Spouse: _____ Cell Phone: _____
Work Phone: _____ May we call you at work? Yes No
E-mail: _____

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

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

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

How did you first hear about us? Friend Internet Search Mailer Drive by
 Yellow Pages Shelter/Clinic Please Specify: _____
=====

Payment Method: ___Cash ___Credit ___Debit ___Check ___CareCredit (90 days 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 24% interest (APR). Any fees incurred in attempting to collect (including collection agency fees, attorney's fees, and court costs) will be added to the outstanding balance. I have read and understand the above statements and agree to all terms therein:

Signature: _____ Date: _____ Drivers License: _____