

# ORCHARD VIEW

## Veterinary Center

### NEW PATIENT FORM

Primary Owner Name \_\_\_\_\_

Previous Veterinary Clinic Name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Phone Number \_\_\_\_\_ May we call to get a history? Yes \_\_\_\_ No \_\_\_\_

Pet's Name _____ (Circle One) Female/Male   Spayed/Neutered? Y/N Birth date/ Age _____ (Circle One) Dog/Cat/Other _____ Breed/Predominant Breed _____ Color(s) _____ Pet Insurance Company _____ Phone Number _____ Policy Number _____ Microchip? Y/N Number _____ Brand _____ Tattoo? Y/N _____ Current Medications _____ Prescription Diet _____ Any chronic health problems? _____
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#### ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED

*Fees not paid in full are subject to a \$5.00 per month handling fee plus 1.5% interest charge.*

**By signing below you agree to the following:**

*The Primary Owner and Co-Owner as filled out on the New Client Form are responsible for all billing and medical decisions made for the above listed pets and any additional pets added on the New Client Form and any additional New Patient Forms. Payment in full is due upon discharge and under certain circumstances, a deposit will be required prior to services being performed. Signee(s) must be 18 years old or older. Photo ID is required.*

Signature \_\_\_\_\_ Date \_\_\_\_\_