CROSS TIMBERS ANIMAL MEDICAL CENTER

2601 Cross Timbers Road
Flower Mound, TX 75028-2717
Phone: (972) 874-VETS (8387)

John R. Harvey, DVM
Dena L. Hartley-Lock, DVM
www.CrossTimbersAMC.com

NEW CLIENT OR PET INFORMATION

Thank you for giving us this opportunity to care for your pet. We'll be happy to answer any questions you have about your pet's health. To insure the best care possible, please take the time to fill in this form completely so that we can best serve both you and your "additional family member". **Italicized information is optional.*

Please check one: ❑ New Client ❑ Current Client – New Pet (Only fill out Client Name & Pet information)

CLIENT INFORMATION

Date: _____

First Name: _____ Spouse: _____ Last Name: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____ Primary/Home Phone: (____) _____

Cell Phone: (_____) _____ Spouse Cell Phone: (_____)_____

*E-Mail Address: _____

When is the best time to call about your pet? _____ At what phone number? _____

Emergency Contact Name: _____ Phone: (_____) _____

How did you learn about our practice? ❑ Hospital Sign ❑ Website ❑ Drive By ❑ Internet: _____ ❑ Other _____

❑ Friend: Who May We Thank for Referring You? _____

**Occupation / Employer:* _____

**Work Phone*: (_____) _____ **Employer's Address:* _____

**Title at work*: _____ If necessary, may we call you at work?: ❑ Yes ❑ No

**Spouse / Other's Work #:* _____

Please list the number of pets you have in your household? _____ CATS _____ DOGS _____Other (please specify)

PET INFORMATION

Pet's Name: _____ ❑ Dog ❑ Cat ❑ Other: _____

Breed:_____ Color:_____ Birthdate/Age: _____

Sex: ❑ M ❑ F Neutered/Spayed: ❑ Yes ❑ No **At what age?* _____ Microchip #?_____

Primary reason for visit:_____

Any known allergies or health care issues we need to know about: _____

**What age was pet obtained?* _____ *From:* ❑ Friend ❑ Breeder ❑ Pet Shop ❑ Humane Society ❑ Other: _____

**Reason for obtaining pet (check all that apply):* ❑ Companion ❑ Protection ❑ Breeding ❑ Show ❑ Other _____

**Previous Caretaker / Veterinary Clinic & Phone # (If records are needed):* _____

PAYMENT IS DUE WHEN SERVICES ARE RENDERED

ADDITIONAL (2ND PET) PET INFORMATION

Pet's Name: _____ ❑ Dog ❑ Cat ❑ Other: _____

Breed:_____ Color:_____ Birthdate/Age: _____

Sex: ❑ M ❑ F Neutered/Spayed: ❑ Yes ❑ No **At what age?* _____ Microchip #?_____

Primary reason for visit:_____

Any known allergies or health care issues we need to know about: _____

**What age was pet obtained?* _____ *From:* ❑ Friend ❑ Breeder ❑ Pet Shop ❑ Humane Society ❑ Other: _____

**Reason for obtaining pet (check all that apply):* ❑ Companion ❑ Protection ❑ Breeding ❑ Show ❑ Other _____

**Previous Caretaker / Veterinary Clinic & Phone # (If records are needed):* _____

If you have additional pets to add, let us know!

AUTHORIZATION / DISCLAIMER:
ALL FEES ARE DUE & PAYABLE UPON COMPLETION OF SERVICES

I HEREBY AUTHORIZE THE DOCTORS AT CROSS TIMBERS ANIMAL MEDICAL CENTER TO PERFORM THE DIAGNOSTIC, THERAPEUTIC AND/OR SURGICAL PROCEDURES THAT THE DOCTORS BELIEVE ARE NECESSARY AND ADVISABLE FOR THE TREATMENT AND MAINTENANCE OF MY PET'S HEALTH. I ALSO AUTHORIZE DOCTORS & STAFF TO PROVIDE ANY OTHER VETERINARY SERVICES THAT I HAVE REQUESTED. IN EMERGENCY CIRCUMSTANCES, STAFF MEMBERS ARE AUTHORIZED TO PROVDIE EMERGENCY CARE AS NEEDED FOR MY PET ON A CONTINUING BASIS UNTIL THEY HAVE BEEN FURTHER ADVISED BY ME VIA A DIRECT PHONE CALL TO THE ATTNEDING DOCTOR OR IN WRITING. THE NATURE OF SUCH SERVICES HAS BEEN DESCRIBED TO ME TO MY SATISAFACTION, AND WHILE I ACCEPT ALL PROCEDUREES TO BE DONE TO THE BEST OF THE ABILITIES OF THE HOSPITAL'S STAFF, I REALIZE THAT NEITHER GUARANTEE NOR WARRANTY CAN BE MADE REGARDING A CURE OR THE RESULTS OF TREATMENT. I UNDERSTAND EVERY EFFORT WILL BE MADE TO ACHIEVE A SUCCESSFUL OUTCOME AND TO PROVIDE FOR ALL POSSIBLE SAFETY IN HOSPITAL CARE AND HANDLING. I HEREBY AUTHORIZE CROSS TIMBERS ANIMAL MEDICAL CENTER TO EXAMINE, PRESCRIBE FOR, TREAT, OR PERFORM SURGERY THE ABOVE-DESCRIBED PET. FURTHERMORE, I ASSUME RESPONSIBILITY FOR ALL CHARGES INCURRED IN THE CARE OF THE ANIMAL AND UNDERSTAND THAT **ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED** UNLESS OTHERWISE ARRANGED. A DEPOSIT MAY BE REQUIRED PRIOR TO SURGICAL PROCEDURES OR EXTENDED HOSPITALIZATION. ANY ACCOUNT LEFT UNPAID IS SUBJECT TO AN ANNUAL % RATE OF 18% (1.5% PER MONTH) AND LATE FEES PLUS A $10 BILLING FEE. I AGREE TO PAY FOR THE REASONABLE COSTS OF COLLECTION, ATTORNEY FEES, AND COURT COSTS IN THE EVENT THAT COLLECTION EFFORTS BECOME NECESSARY. I AGREE THAT THE VENUE OF THIS ACTION WILL BE IN THE COUNTY WHERE THE HOSPITAL IS LOCATED. I UNDERSTAND THAT VETERINARY SERVICE IS PROVIDED DURING NIGHTTIME HOURS AS NECESSARY IN THE JUDGMENT OF THE VETERINARIAN IN CHARGE. CONTINUOUS PRESENCE OF QUALIFIED PERSONNEL MAY NOT BE PROVIDED.

A WRITTEN ESTIMATE WILL GLADLY BE PROVIDED IF REQUESTED, JUST ASK DOCTOR, TECHNICIAN OR RECEPTIONIST.

Method of Payment: ☐ Cash ☐ *Check ☐ Visa® / MasterCard® / Discover® / AmEx® ☐ Other ____
*For ***CHECK WRITING*** privileges, please include Drivers License Number: _____
DL State & Expiration Date: _____

Signature of Client: _____ Date: _____

ALL INFORMATION PROVIDED IS STRICTLY CONFIDENTIAL