"Thank you for choosing us to take care of your pets"

Client Information

Name: ____ Your D.O.B. ______________ Acct # __________________
First Last Mo/Day/Yr (office use only)

Co-owner's Name: ____Relation:__________________________

Address: ____
Street City State Zip Suite/Apt. #

Home Number: _____________________________________ Cell Phone: _________________________________

Work Phone: _______________________________________ Preferred Number Home / Cell / Work

Email: ____ Driver's license #________________
(reminders, current promotions, newsletters, and important updates. NO SPAM!)

Pet Information

Name: ____ Breed: ____________________________________

Color/Markings: ___________________________________ Birth date/Age: ____________________________

Sex (male/female): _________________________________ Spayed/Neutered: Yes / No

Microchip number: _______________________ If none, does your dog wear a name tag on their collar? Yes / No

Previous Veterinarian's Name & Phone Number: ____

Is your animal aggressive or does he/she bite? ____

Reason for today's visit: ____

How did you hear about us? ____

Would we have your consent to post you or your pet(s) picture on our website and/or Facebook page? Yes / No

TERMINATING SERVICES

Chastain Animal Clinic values a meaningful and productive relationship with our patients and clients. Unfortunately, there are occasions where this is no longer feasible. Please be advised that our Practice reserve the right to terminate the patient/client/veterinarian relationship for any of the following reasons:

Medical Non-Compliance Failure to pay an outstanding balance Account sent to collections
Rude, abusive behavior, use of obscene language, mistreatment of the staff in person or over the phone

In such cases where the practice terminates the relationship, we will send your pets medical records to your new provider at no cost to you. I understand that I can request a written estimate of fees for any treatment, emergency care, surgery, or hospitalization. I understand that a deposit may be required before treatment. I understand that all fees are due when services are rendered. If for any reason there is a balance on my account past 30 days, I will incur late fees and/or interest on the balance owed.

Signature: ____ Date: ____________________

Chastain

Animal Clinic

Photo Testimonial Release Form

I _________________________________, give Chastain Animal Clinic the right to use my testimonial (or photo) provided for reproduction in any medium including but not limited to; website, video, broadcast, print, and electronic means for purposes of advertising, trade, display, exhibition or editorial use. Further, you also (i) agree to release Chastain Animal Clinic from all claims for libel, slander, invasion of privacy, infringement of copyright or right of publicity or any other claim and (ii) confirm that you are over the age of 18 years old.