

Angel Animal Hospital
15505 Tamiami Trail
Naples FL 34110

New Client Form

Name(Last) _____ (First) _____

Address: _____

City _____ State _____ Zip _____

Community (If Applicable): _____

Phone Numbers:

H _____ C _____ OTHER _____

Email _____

Pets: 1. Name _____ Age _____ Breed _____
Spayed / Neutered? Y N Microchipped? Y N

2. Name _____ Age _____ Breed _____
Spayed / Neutered? Y N Microchipped? Y N

3. Name _____ Age _____ Breed _____
Spayed / Neutered? Y N Microchipped? Y N

Do you currently have Pet Insurance? Y N If not would you like information? Y N

How did you hear about us? Google Facebook Yahoo Bing Referral Drive-By
 Other _____ If you were referred, who referred you? _____

PLEASE CHECK IF YOUR PET HAS HAD ANY OF THE FOLLOWING:

1. **Weight:** Gain ____ Loss ____ none mild moderate severe
2. **Appetite :** Increase ____ Decrease ____ none mild moderate severe
3. **Vomiting ____ Diarrhea ____** none mild moderate severe
4. **Constipation/(Difficult Defecation)** none mild moderate severe
5. **Increased Drinking ____ Urination ____** none mild moderate severe
6. **Lumps/Tumors ____ Skin Problems ____** none mild moderate severe
7. **Bad Breath/Sore Gums/Difficulty Chewing** none mild moderate severe
9. **House Soiling ____ Spraying ____** none mild moderate severe
10. **Chewing/Licking/Eating Non-Food Items** none mild moderate severe
12. **Increased Irritability ____ Aggression ____** none mild moderate severe
13. **Increased Fear ____ Anxiety ____** none mild moderate severe
15. **Decreased Hearing or Selective Hearing** none mild moderate severe
16. **Repetitive Behaviors (i.e., pacing/grooming)** none mild moderate severe
17. **Decreased Grooming or Self-Care** none mild moderate severe
19. **Weakness ____ Uncoordination ____** none mild moderate severe
20. **Difficulty Climbing Stairs/Increased Stiffness** none mild moderate severe
21. **Decreased Activity—Sleeps More** none mild moderate severe

Any other concerns today? _____

ANGEL ANIMAL HOSPITAL & BOARDING
15505 TAMIAMI TRAIL N
(239) 221-8444

FINANCIAL POLICY

You are responsible for payment of all services rendered at the time such services are performed. Any payment concerns, or requests for estimates, are to be addressed to the receptionist prior to the examination. Estimates will be provided for any services upon request.

***Finance charges will be applied to any late payments. If you need to cancel an appointment, please notify our office within 24 hours. Two missed appointments will result in a \$25.00 fee per pet.**

INITIALS: _____

Policy Concerning Unpaid Bills/Abandoned Pets

If you do not pick up your pet within ten days of its release date, your pet will be considered abandoned. You will be billed for treatments and boarding incurred up to the date you pick up your pet. Attorney fees and court costs, plus collection fees will be turned over to a national collection agency and reported to the appropriate credit bureaus to be placed on your credit report.

INITIALS: _____

Authorization

I have read and understand the above policy and request treatment of my pet in accordance with these policies. I assume financial responsibility for all charges incurred to the patient and agree to pay all costs of collection, reasonable attorney fees, and court costs in the event of non-payment.

SIGNATURE: _____ DATE: _____

***Thank you for allowing us to care for your pet.
We hope that you find our facilities and staff provide the best veterinary care
available to your pet.***