



CORAL BREEZE ANIMAL HOSPITAL
NEW CLIENT/PATIENT INFORMATION FORM
8893 S Military Trail, Boynton Beach, Fl 33436
Christopher Carmona, DVM & Maite Cintrón, DVM

Welcome to Coral Breeze Animal Hospital. We look forward to serving you and caring for your pet's needs for many years to come. Please complete the following information for our records:

OWNER INFORMATION:

Name: _____ Email: _____ (F or hospital updates/specials/reminders)

Address: _____
NUMBER STREET CITY ZIP CODE

Phones: Home: _____ Cell Phone: _____ Business: _____ ext. _____

Who else is responsible for your pet? Name: _____ Relationship: _____

Address (if different from above): _____

Phones: Home: _____ Cell Phone: _____ Business: _____ ext. _____

PATIENT INFORMATION:

Pet's Name: _____ Dog Cat Male/Female: Spayed/neutered/unaltered (*please circle*)

Breed: _____ Colors/Markings: _____ Birthdate: _____

Any disease your pet has been diagnosed with: _____

Current medications: _____

Does your dog have any history of aggression towards people or other animals? Yes No

How did you hear about our clinic? Phone Book Drive By Website

Other _____ Referral Whom may we thank for referring you? _____

We pledge to do our very best to care for your pet's health needs. In return, we ask you to accept the responsibility for charges incurred in the treatment of your pet. Please feel free to ask for an **Estimate** prior to providing services. If at anytime you are not satisfied with our services, please let us know. We will be happy to answer your questions.

How do you plan to pay for today's services? Cash Debit Credit Card

We accept VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, and we offer Care Credit if you need a payment plan. **NO CHECKS ACCEPTED.** _____ (*please initial*)

I hereby authorize the veterinarian to examine, prescribe for, and treat the above-described pet. I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid at the time of release, and that a deposit may be required for hospitalization, surgery, boarding or treatment. In the event of default, I will be responsible for any legal fees and/or collection costs and a finance charge of 1.5 % per month (18% per annum).

Owner's Signature: _____ Date: _____

SAVE FOR OFFICE USE ONLY:

X-ray Number: _____ Alerts: _____

Microchip: _____ Misc: _____