COUNTRY INN ANIMAL HOSPITAL
NEW CLIENT INFORMATION

File #:

Owner's Last Name:	First Name:		Spouse/Other:
Address:	Apt. #:	City:	
State:	Zip Code:	Home Phone:	Cell Phone:
Work Phone:	Fax:		E-mail Address:
Emergency Contact Name:		Phone #:	

How did you become aware of our hospital? _____

Name of Previous / Current Vet: _____

Pet # 1	Pet # 2	Pet # 3
Name:	Name:	Name:
Species / Breed:	Species / Breed:	Species / Breed:
Color:	Color:	Color:
Date of Birth or Age	Date of Birth or Age	Date of Birth or Age
Sex: F / M Spayed/Neutered?	Sex: F / M Spayed/Neutered?	Sex: F / M Spayed/Neutered?
Microchip #:	Microchip #:	Microchip #:

Method of Payment: ____Cash / Credit Card #: _____ Exp.____/___**(NO CHECKS ACCEPTED)**

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 this hospital to receive, prescribe for, treat or perform surgery upon the pet(s) listed above. Furthermore, I agree to pay fees for all services rendered at the time the pet is discharged from the hospital or the service is otherwise terminated. 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.

This application must be presented with a valid Driver's License.

Signature: _____ Date: ____/____/____

2100 Flamingo Road, Davie, FL 33325 Hospital 954-424-6525 Resort: 954-424-6000 Fax: 954-424-6265
www.countryinnpetresort.com