Brook-Ellis Pet Hospital

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Welcome to Our Practice - New Client Form

Thank you for giving us the opportunity to care for your pet! Please help us meet your needs better by taking a moment to share some important information. Must be 18 years of age or older to complete this form.

Primary Contact Name

Primary Contact Phone Number

Primary Contact Email Address

Secondary Contact Name & Number

Secondary Contact Email

Home Street Address

City

State

Zipcode

Owner's Date of Birth

How did you hear about us?

- ☐ Family/Friend (please indicate below)
- ☐ Internet search
- ☐ Facebook/Instagram/Social Media
- ☐ Other (please indicate below)

Do you currently use pet insurance, boarding or daycare facilities, specialty vets, or have any other affiliations you'd like us to know about?

_____

Photograph and Video Release: There may be times we would like to share a photo or video of your pet with our social media sites (including but not limited to our website, Facebook, Instagram, etc.) Please indicate your wishes below:

○ I hereby grant permission to use my pet(s) photograph or video on social media, website, promotional materials, etc, without compensation. Materials will become the property of the hospital.

○ I decline the use of my pet(s) photograph or video on any social media, website, promotional materials, etc.

I, _____, the undersigned, am the owner or agent for the owner of the animal(s) described, and I have the full and exclusive authority to execute this consent.

- I certify that I am 18 years of age or older.
- I give permission to doctors, staff, authorized agents, or representatives of this hospital to examine, prescribe for, and treat my pets.
- I agree to pay for all services rendered and medications, goods, and supplies when purchased.
- I understand that all fees are due at the time services are rendered and the hospital accepts cash, check, and all major credit cards.
- I understand that a deposit may be required for surgical or medical treatment.
- I understand that if my pet ever requires overnight hospitalization, there will not be overnight supervision provided.
- I release this hospital from any and all liabilities.

By my signature below, I hereby acknowledge that I agree to all of the above and acknowledge the receipt of a copy of this agreement upon request.

Owner/Agent Name **Date**

_____ _____

Owner/Agent Signature

_____

Is there anything else you'd like us to know?

_____