

Phone: 225.245.5032

Fax 225.245.5031



NEW CLIENT INFORMATION

Thank you for choosing St. Francis Animal Medical Center for the care of your animals. Please fill out the information below so that we may keep a health record for reference.

Please Print

Owner Name _____ Mr. Mrs. Ms. Dr.

Address _____ Home Phone _____

City, State, Zip _____ Cell Phone _____

Place of Employment _____ Position _____

DL or State ID # _____ State Issued _____ Email _____

Spouse/Partner Name _____ Mr. Mrs. Ms. Dr.

Address _____ Home Phone _____

City, State, Zip _____ Cell Phone _____

Place of Employment _____ Position _____

DL or State ID # _____ State Issued _____ Email _____

How did you first become aware of our Veterinary Hospital?

- Previous Client Another Hospital _____
- Personal Recommendation (whom may we thank?) _____
- Other _____

***The following individuals are authorized to make health and Financial Decisions for all my current and future pets. I understand that I am Responsible for keeping this information current and that my outstanding charges on this account will be my responsibility:** _____

TO HELP PREVENT THE SPREAD OF INFECTIOUS DISEASES, ALL HOSPITALIZED AND BOARDED ANIMALS MUST BE CURRENT ON ALL VACCINATIONS REQUIRED BY THIS PRACTICE, AND BE FREE OF EXTERNAL PARASITE INFESTATIONS.

Name of previous veterinarian _____ Phone _____

Today's payment will be Cash Check Visa Mastercard Discover American Express
 Apple Pay People Pay

******ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED****** When extensive care is indicated, a deposit may be required up front. A written estimate will be provided upon request.

Should I fail to pay for any service rendered by St. Francis Animal Medical Center, I will be responsible for all service charges (18%) and collection charges (33%) incurred by the Practice. There is a \$35.00 NSF fee on checks returned for non-payment.

_____ Date

_____ Signature of Owner or Authorized Agent