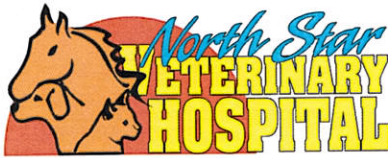


Client ID: _____
Initials: _____



532 Canady Road
Parkton, NC 28371
910.858.2525

Thank you for giving us the opportunity to care for your pets!
Please take a moment to fill out this form to better support your pet's health care needs.

Client (Owner) Name: _____ Spouse/Secondary Name: _____
Owner Date of Birth: _____ Driver's License #: _____ State: _____
Address: _____ City: _____ State: _____ Zip: _____
Client Cell Phone: _____ Home Phone: _____ Spouse Cell: _____
E-Mail Address: _____ Military? Yes No

Providing your email address, adds convenience of receiving lab results, reminders, schedule appointments and access our online store!

How did you hear about us? Internet Sign Friend: _____
We offer a \$25 referral credit, so don't forget to tell your friends/family!

Pet Information:

Name	Age	Breed	Sex Spayed/Neutered	Color

Has your pet(s) been seen by another veterinary hospital? Yes No
If so, may we retrieve their records? Yes No
Hospital Name: _____ City: _____ State: _____

SOCIAL MEDIA POLICY: At North Star Veterinary Hospital, we like telling your pets' stories on our Facebook page, including their name. However, client information will not be shared.

I give permission for my pet to appear on NSVH's Facebook. I do not give permission.

PAYMENT POLICY: Payment is *due at the time of discharge*. In cases of extensive medical/surgical procedures, we accept MasterCard, Visa, Discover and Care Credit. We will gladly prepare a written estimate at your request.

This information is true and accurate to the best of my knowledge. I understand that I am responsible to pay North Star Veterinary Hospital for services rendered, including reasonable attorney fees and costs of collections in the event of default. I further understand that payment is due at the time of service and if account becomes thirty days past due, delinquency charges are assessed at a monthly rate of 18% or a 1.5% monthly charge, whichever is greater. Returned checks are charged a service rate of \$25.

I understand that in order to keep costs low, that if I miss my appointment without at least a 24 hour prior notice, my account will be charged \$25 missed appointment fee. Missed surgical appointments, will be charged a \$50 missed surgical appointment fee.

Signature: _____ Date: _____