Animal Medical Center
OF HIGHLAND VILLAGE

New Client Form

First Name:_____

Last Name:_____.

Secondary Contact Name:_____

Phone Number:_____

Secondary Phone:_____

Email:_____

Preferred Method of contact: Call __ Text __ Email __

Address Line 1:_____

Address Line 2:_____

City:_____ State:_____ Zip Code:_____

How did you hear about us?_____

Who can we thank for your referral?_____

ALL FEES ARE DUE UPON COMPLETION OF SERVICES

I hereby authorize the examination, prescription for, and/or treatment of my pet(s). I assume responsibility for all charges incurred in the care of this/these pet(s). I agree to pay all fees for all services rendered at the time the pet(s) is/are released from our care. Failure to pay on an active balance will result in a 15% service charge.

Acceptance: (please initial) ____

Signed:_____ Date:_____