# Marietta Animal Hospital
# New Client Information

Owner's Name: ______________________________________ DOB: ____________

Address: ____________________________________________________________

City: __________________ State: _____ Zip Code: ________ County: ________

Cell Phone: _____________ Alt Phone: ____________ Work Phone: ____________

Email: ______________________________________________________________

Co-Owner's Name: __________________________________ DOB: ____________

Address: ____________________________________________________________

City: __________________ State: _____ Zip Code: ________ County: ________

Cell Phone: _____________ Alt Phone: ____________ Work Phone: ____________

Email: ______________________________________________________________

**Please Let Us Know if You Are:**

__ Senior __ Teacher __ Military __ First Responder __ Law Enforcement

(Active or Retired)

**Preferred Method of Contact:**

__ Call __ Text __ Email __ No Preference

**How did you become aware of our clinic?**

__ Location/Sign __ Google __ Facebook __Yelp __ Flyer

__ Client __ Employee (Who may we thank? _____________________ )

*** PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED ***

We accept ***Cash, Visa, Mastercard, Discover, American Express, and Care Credit***. I, the undersigned owner or authorized agent of the patient(s), hereby authorize the doctors of Marietta Animal Hospital to administer such treatment as is necessary and to perform procedures therapeutically and/or diagnostically. I further understand that no guarantee of successful treatment is made. I also assume financial responsibility for all charges incurred and agree to pay all such charges at the time of release. I understand that unpaid balances over 30 days are subject to a monthly 1.5% finance charge.

Signature: ___________________________________________ Date ______________