



UPSTATE VETERINARY SPECIALTIES PLLC
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New Client Information Form

Last Name: _____ First Name: _____
Spouse: _____
Street: _____
City: _____ State: _____ ZIP: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Fax Phone: _____
Email: _____
Today's Payment (circle one): Visa MasterCard Discover CareCredit AmEx Check Cash

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Regular Veterinarian _____ Regular Hospital _____

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Pet Information

Pet's Name: _____ Weight: _____ (Please use scale)
Please check one: Dog _____ Cat _____ Other _____
Breed: _____ Color: _____
Male (unaltered) _____ Female (unaltered) _____ Male Neutered _____ Female Spayed _____
Birthdate: Month _____ Day _____ Year _____
Reason For Referral: _____

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AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT AND FINANCIAL RESPONSIBILITY

I hereby authorize the doctor and designated technicians on duty to administer treatments considered therapeutically necessary. I understand that the estimated fee is based on treatment deemed necessary at the time of admission. In many cases it is impossible to determine in advance full cost of treatment required and may vary depending on the diagnostics, medication, treatment, or surgery not contemplated at this time. I understand that all fees are to be paid in full at the time of service. I further understand that if payment becomes 30 days past due, delinquency charges will be due.

SIGNATURE _____ DATE _____