Client Referral_____

Welcome_____

Aloha Animal Hospital Associates

Thank you for giving Aloha Animal Hospital & Associates the opportunity to care for your pet .
So that we may become better acquainted, please complete the following.

Client Information:

Owner's Last Name | First Name | Middle Initial | Last 4 digits of Social Security #

Mailing Address | City | State | Zip Code

Billing Address (*if not the same as above)* | City | State | Zip Code

Home Phone | Work Phone | Cell

E-Mail: _____ Use my e-mail for reminders: ☐

Alternative Contact:

Last Name | First Name | Relationship

Alt Home Phone | Alt Work Phone | Alt Cell

How did you become aware of our Hospital?

Yellow Pages ☐ Hospital Sign/Location ☐ KHON ☐ School Tour ☐ Internet, Site: _____

Personal Recommendation, Name: _____ Doctor/Clinic, Name: _____

Pet Information:

Pet's Name _____ Species/Breed _____ Male ☐ Female ☐ Altered ☐

D.O.B ___ - ___ - ___ Color _____ Identification (tag#/microchip#) _____

Terms of Payment

- **Payment <u>in Full</u> is required at the time of service**
- Acceptable forms of payment
  1. Cash 2. Check 3. Credit Card (VISA, MasterCard, American Express, Discover) 4. Care Credit
- No billing
- Payment Plan Options:
  - We, personally, do not offer payment plan options
  - American Agencies – collection agency or Care Credit
    - 10% interest added to the principal amount (for accounts sent to American Agencies)

Signature of Owner _____ Date: _____