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: ________

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.

You may leave a credit card on file for the ease of making a payment over the phone for work done or prescription refills. By filling out the form below, I authorize North Star Veterinary Hospital to run my provided credit card information for payment of work done for my pets.
MC/V/D/Care Card #: ________-________-_______-_______ EXP: _____/______ CVV Code: _________

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 deault. 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: _____________________________