Avenue Animal Hospital
1725 N. Mount Juliet Road
Mount Juliet, TN 37122
615-553-4855
www.aahtn.com

New Client Form

Welcome to our practice! Thank you choosing us to care for your pet. Please help us to better meet your needs by sharing some important information necessary to support your pet's need today and in the future.

Owner's Name:			
Home Address:			
City, State, Zip:		**County:**	
Home Phone:		**Cell Phone Number:**	
Employer:		**Work Phone Number:**	
Employer's Address:		**Email Address:**	
Driver's License Number/State:			

Co-owner's Name:			
Home Address:			
City, State, Zip:		**County:**	
Home Phone:		**Cell Phone Number:**	
Employer:		**Work Phone Number:**	
Employer's Address:		**Email Address:**	
Driver's License Number/State:			

How did you hear about us? ☐ Internet (Google, Yelp) ☐ Facebook ☐ Clinic Website
☐ Road Sign/Drive By ☐ Print Ad ☐ Existing Client:
☐ Other:

Preferred reminder / contact method: ☐ Email ☐ Regular mail

List Names, other than those listed above, who have authorization to approve treatment of any kind to the patient named below:

Professional fees are due when services are rendered. We will gladly prepare an estimate for you if requested. Accounts are subject to costs of collection, attorney fees, and interest. Returned check fee is $25. By signing below, I understand all outstanding balances may be turned over to collections without further notice. If my account is turned over to collections, I understand I am responsible for all collection fees including, attorney fees, court costs, and interest. I also agree to submit to the jurisdiction of the Courts of Wilson County, Tennessee.

I grant Avenue Animal Hospital permission to post my pet's picture, story, and medical information on social media. ☐ Yes ☐ No

______________________________ ______________________

Signature **Date**

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Pet Information

Pet's Name:		Date of Birth:	
Species: circle	Canine or Feline	Breed:	
Sex: circle	Male or Female	Neutered/Spayed?	Yes or No
Description / Color:			
Medical Conditions:			
Allergies:			
Date of Last Vaccinations:			

Pet's Name:		Date of Birth:	
Species: circle	Canine or Feline	Breed:	
Sex: circle	Male or Female	Neutered / Spayed?	Yes or No
Description / Color:			
Medical Conditions:			
Allergies:			
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Please list the name and address of any veterinary hospital(s) at which your pet(s) is/was a patient:

Providing your pet with the best care is very important to us. If you are transferring services from a previous veterinarian, please arrange for transfer of your pet's medical records. We can request these for you if you sign an authorization form. They can be faxed directly to us at 615-553-4873.