Coastal
Veterinary Dermatology
& Ear Clinic

HOSPITAL USE ONLY		
Weight:	#/	kg
Room #:		
Time:		

New Patient Intake Form

Client Information

First Name: Last Name: M.I.: SS# or DL#:

Authorized Guardians:

Mailing Address:

City: State: Zip Code:

Home Phone: Work Phone: Cell Phone:

Email: Preferred Contact Method:

How did you hear about us? ☐ Internet/Facebook ☐ Radio/TV ☐ Magazine/Newspaper ☐ Family/Friend ☐ Veterinarian ☐ Other

Primary Care Veterinarian:

Patient Information

Patient's Name: Species: ☐ Canine ☐ Feline ☐ Other Color:

Breed: ☐ Male ☐ Female ☐ Neutered ☐ Spayed Birthdate or Age:

Initial Presenting Problem:

Treatment Authorization and Photo/Information Release

I hereby authorize Coastal Veterinary Dermatology & Ear Clinic (CVD) to perform medical and initial diagnostic/surgical procedures on my pet as required for diagnosis and treatment. I understand that I can terminate treatment at any time by contacting the doctors or assistants.

If I have been referred to this hospital by another veterinarian, I understand that they will require a summary of care and treatment provided by CVD in order to ensure that my pet's care can be continued without interruption. I also understand that CVD considers the identification of a primary care veterinarian by me to be my authorization to release records and information to that veterinarian.

As teachers in the veterinary medical field, the Specialists of CVD may use medial case information for teaching, developing forms, providing continuing education, web sites and veterinary literature development and social medial updates. I authorize the release of case/patient information, including photographs for such purposes. Patient confidentiality (client names withheld) will be maintained.

By submitting any photo to CVD, you agree to the following: I certify that I am 18 years of age or older, and I am the sole owner of the photograph(s) I submit to CVD. I agree not to email any photograph(s) protected by copyright without the express permission of the owner of the copyright. I grant CVD the right to reproduce, distribute, publish, display, edit, modify, create derivative works and otherwise use the photograph(s) for any purpose in any form and in any media. I agree to indemnify CVD for all damages and expenses that may be incurred in connection with the photograph(s), including but not limited to the publication of the photographs on www.coastalvetderm.com and to use my name in connection therewith if CVD so chooses.

In the event I transfer ownership, etc. to another party, I authorize release of medical information to the new owner, should they request it.

Financial Policy

Payment is due as services are rendered. For hospitalized patients, a deposit is required in advance. The balance is due upon discharge from the hospital. Payment may be by cash, personal check, or accepted credit cards. In order to avoid misunderstandings, please let us know immediately if these terms are not satisfactory.

A service fee of $3.00 and 1.5% of the outstanding balance will be charged to your account monthly if not paid in full. If applicable, you will be responsible for any lawyer and/or collection agency expenses that may be incurred. Returned checks are subject to penalties under the Texas Penal Code – Section 32.41. For additional information on the Texas Bad Check Law, see http://www.jp.hctx.net/checks/info.htm.

I understand that I, as the owner or agent, am financially responsible to CVD for all charges relating to this patient. I have read and agree to the treatment authorization. I have also read and accept the financial obligations.

Signature: _____ Date: _____