MOUNTAINSIDE ANIMAL HOSPITAL
& 24 Hour Emergency Services

# New Patient Form

604 973 1247 info@mountainside24er.ca

PLEASE PRINT CLEARLY

**Patient Information**

| | |
|---|---|
| Pet's Name: | Species: ☐Canine ☐Feline ☐Other |
| Breed: | Color: |
| Sex: ☐ Female Spayed ☐Female Intact ☐Male Neuteured ☐Male Intact | |
| Age or Birthday (mm/dd/yyyy): | |
| Insurance Provider and Policy Number: | |
| Regular Veterinary Clinic*: | |
| **You are authorizing direct transfer of medical records to the party above following treatment at MAH. We will provide medical records upon request to yourself or any licensed veterinary clinic requesting records on your behalf.* | |

**Client Information (Owner)**

| | | |
|---|---|---|
| First Name: | Last Name: | |
| E-mail*: | | |
| **This e-mail is for communication of consent, medical records, and payment information only; you will not receive any spam from MAH.* | | |
| Address: | | |
| Unit#: | City: | Postal Code: |
| Mobile: | Landline: | |

**Secondary Contact**

| | |
|---|---|
| First Name: | Last Name: |
| Phone Number: | |
| **By listing the party above, you authorize them to make medical/financial decisions for the patient.* | |

**Do you give permission for us to share photos of your pet on social media?**

☐Yes, Tag me at: @ _____ ☐No

How did you hear about us? _____

Signature: _____ Date: _____

***NOTE: Verbal harassment, abusive behaviour, foul language, physical assault, and threats will not be tolerated and may result in termination of services.**

**PLEASE, LEAVE THIS FORM BY THE FRONT DOOR.**