

# Pieper Veterinary - Referral Client NEW CLIENT/PATIENT QUESTIONNAIRE



## Client Information

Owner Name: \_\_\_\_\_ Co-owner Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Co-owner Phone: \_\_\_\_\_ Email: \_\_\_\_\_

## Patient Information

Pet Name: \_\_\_\_\_  Canine  Feline  Other: \_\_\_\_\_  
Breed: \_\_\_\_\_ DOB/Age: \_\_\_\_\_ Color: \_\_\_\_\_  
Sex:  Female  Male Has your pet been neutered or spayed?  Yes  No

- Does your pet have a current rabies vaccine?  Yes  No
- Have you ever been to this facility before?  Yes  No
- Have you ever visited any of our practices listed below? *(please check any that apply)*  Yes  No  
 Pieper-Olson  East Haddam  Essex  
 Marlborough  Middletown  Pieper Memorial Madison
- Do you have a primary care veterinarian/practice who provides regular, annual, routine veterinary services to this pet or other pets in your household?  Yes  No  
If yes, name of primary care veterinarian/practice: \_\_\_\_\_  
*(Medical reports will be sent to this veterinarian/practice)*
- Does your pet visit any other veterinary practices? \_\_\_\_\_
- Who referred you to this practice?  Family/Friend  Your Veterinarian  Our website  
 Yelp  Google  Other: \_\_\_\_\_

Does your pet have insurance? Please list company: \_\_\_\_\_

## Services

We are a 24-hour emergency and specialty care facility. We provide local and referring veterinarians with after hour emergency services, specialized medical procedures and critical care hospitalization for their clients' pets. Our understanding with referring veterinarians is that they will provide follow-up services and continued care once our specialized services are no longer necessary. **Therefore, we are not able to provide routine veterinary care for outside referring veterinarian's clients here or at any of our other general practice locations.**

## Payment Policy

Following a doctor's examination, we will provide you with an estimate of fees for your pet's medical care. You will have the opportunity to approve or decline all recommended procedures or medications. Your estimate will be adjusted to reflect only the services that you wish to pursue. **Upon approval of the estimate, a deposit is required to begin diagnostics and treatment on your pet. THE BALANCE IS DUE AT DISCHARGE. If you cannot meet this requirement, we have staff members who can assist you in applying for Care Credit (see provided brochure).** If you have any concerns, please feel free to consult our reception staff.

**Please initial after reading:** \_\_\_\_\_

CLIENT SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

-----*(Office use only below this line)*-----

Printed name of staff member accepting/checking form with Client: \_\_\_\_\_

Printed name of staff member conducting search and correcting information: \_\_\_\_\_