



Central Veterinary Hospital  
1212 W. Clinch Ave.  
Knoxville, TN 37916  
(865) 525-1167



**NEW/UPDATED CLIENT FORM**

*Thank you for giving us the opportunity to care for your pet(s). Please complete the following:*

Name \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
Address \_\_\_\_\_ Apt \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Place of Employment \_\_\_\_\_  
Spouse's P.O.E \_\_\_\_\_ Spouse work phone \_\_\_\_\_  
E-mail Address \_\_\_\_\_  
Best time and number to reach you \_\_\_\_\_  
Driver's License # & Issuance State \_\_\_\_\_  
Social Security Number \_\_\_\_\_

Under the laws of HIPAA (Health Insurance Portability and Accountability Act), we can not disclose any personal information about you or your pet to anyone unless otherwise specified by you.

**\*The following individuals are authorized to make health and financial decisions for all my current and future pets. I understand that I am responsible to keep this information current and that any outstanding charges on this account will be my responsibility:**

---

---

How did you become aware of our clinic?    Drove by    Previous Client    other:  
Personal recommendation (Whom may we thank?) \_\_\_\_\_

Indicate choice of payment:    Cash    Check    Visa/MC/Discover/AmEx    CareCredit  
**\*\*\*ALL FEES ARE DUE AT TIME SERVICES ARE RENDERED\*\*\***

Should I fail to pay for any services rendered by Central Veterinary Hospital, I will be responsible for all service charges (18%) and collection charges (33%) incurred by the hospital.

CLIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

CRS Initials: \_\_\_\_\_ Client number: \_\_\_\_\_