Lonestar Animal Hospital. P.A.
10211 Sharptown Road
Mardela Springs, MD 21837

NEW PATIENT REGISTRATION

PET INFORMATION

Pet's Name:_____ Circle One: Dog/Cat Male/Female Neuter/Spayed

Breed:_____ Color:_____ Date of Birth: _____

Previous Vaccinations/Veterianarian:_____
Any Known Drug Allergies/Sensitivities?_____
Any Previous Major Medical/Disposition Problems?_____
Reason For Visit:_____
I **allow** our pet's picture to be on **Lonestar's** website/facebook page: ___yes ___no

OWNER INFORMATION

Last Name:_____ First Name:_____ MI:_____
Co-Owner/Spouse:_____ MI:_____
Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____ Alternate No.:_____
Cell No.:_____ e-mail:_____
May All Be Used For Contact? Yes___ No___

Employer's Name & Address:_____
Occupation:_____ Work No.:_____

Spouse's Employer & Address:_____
Occupation:_____ Work No.:_____

Social Security No.:XXX-XX-_____ Spouse's SS No.:XXX-XX-_____
Driver's Lic. No./State:_____ Spouse's DL No./State:_____

How Did You Learn About Us?_____

Professional Fees Are Due At The Time Services Are Rendered
We Accept: Cash/Debit Checks Visa Mastercard Discover Care Credit

I assume responsibility for all charges incurred in the care of this animal. I understand that these charges must be paid at the time of services unless payment arrangements are made in advance. Any balance carried is subject to a 2.0% Monthly Finance Charge and a $1.50 Billing Charge. With any payment arrangements, if the undersigned fails to make any payments due hereunder, hospital may at anytime thereafter, without notice or demand, declare the entire unpaid balance of the account to be immediately due and payable. The undersigned promises to pay all cost of collection, including, but not limited to court costs, attorneys fees equal to 15% of any amount due and owing to the hospital, and any other collection fees which are incurred by or on behalf of the hospital in enforcing payment after default.The undersigned expressly agrees and stipulates that if, in the sole discretion of the hospital, its representatives or its attorneys, litigation or court process is necessary to enforce payment hereunder, that the venue for such litigation or court process shall be the Circuit Court for Wicomico County, Maryland, or the District Court of Maryland for Wicomico County, Maryland, and the undersigned hereby expressly waives any right of venue or trial in any county or jurisdiction other than Wicomico County, Maryland.

SIGNATURE:_____ **Date:** _____
(Owner or Responsible Party)