



Thank you for giving us the opportunity to care for your pets.
So that we may become better acquainted,
please complete the following.

Date 9/9/2010
Account

CLIENT INFORMATION

Name _____ Home Phone _____ Mobile Phone _____
 Address _____ Date of Birth _____ Employer _____
 City/St/Zip _____ 2nd Owner Name _____
 County _____ 2nd Owner Employer _____
 E-Mail _____ 2nd Owner Work Phone _____

PATIENT INFORMATION	Pet #1:	Pet #2:	Pet #3:
Name			
Breed			
Date of Birth			
Color			
Sex/spayed or neutered?			
Any previous serious illnesses or surgeries			
Any allergies to vaccinations or medications			
Special diets or medications			
Rabies vaccine			
Distemper vaccine			
Kennel cough vaccine			
Lyme disease vaccine			
Fecal (stool sample)			
Feline leukemia vaccine			
FIP vaccine			
Heartworm test/prevention			

Would you like to be present during treatment of your pet(s)? Yes No

How did you become aware of our clinic? Drove By Yellow Pages Website
 Personal Referral (Whom may we thank?) _____
 Other _____

PROFESSIONAL FEES ARE TO BE PAID AT THE TIME OF DISCHARGE. PLEASE CHECK YOUR PREFERRED METHOD OF PAYMENT BELOW.

We will gladly prepare a written estimate if you desire. Please ask the receptionist or doctor.

Please indicate choice of payment: Cash Visa MasterCard Care Credit

I AM RESPONSIBLE AND AGREE TO PAY IN FULL THE TOTAL CHARGES FOR SERVICES RENDERED AT THE TIME OF DISCHARGE AND ANY FEES INCURRED FOR COLLECTION OF SAID CHARGES. I UNDERSTAND THAT THE FEES ARE BASED ON TREATMENT DEEMED NECESSARY AT THE TIME OF EXAM, TREATMENT OR ADMISSION AND THAT THE ESTIMATE FEE MAY BE RAISED OR LOWERED BY THE ADMINISTRATION OF TREATMENT, MEDICATION, SURGERY OR DIAGNOSTIC TEST.

Signature _____ Date _____

Signature of person presenting this pet for treatment if other than owner _____

Name _____ Relationship to Owner _____

Full Address _____ Telephone _____