Best Care Pet Hospital

Client Information Sheet

OWNER'S NAME: Mr. Mrs.
Miss_____

ADDRESS: _____CITY: _____ STATE: _____

ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

CELL: _____

E-MAIL ADDRESS: _____

E-MAIL REMINDERS? YES NO

EMPLOYER: _____

ADDRESS: _____

SPOUSE'S NAME: Mr. Mrs.
Miss_____

WORK PHONE: _____

CELLULAR/BEEPER: _____

EMPLOYER: _____

ADDRESS: _____

PET'S NAME: _____ BREED: _____

DOB (OR AGE) _____

MALE or FEMALE (circle one) NEUTERED or SPAYED or UNALTERED (circle one)

PET'S NAME: _____ BREED: _____

DOB (OR AGE) _____

MALE or FEMALE (circle one) NEUTERED or SPAYED or UNALTERED (circle one)

Relative or Friend We May Contact in the Event of an Emergency (Other than Above)

NAME: _____

PHONE NUMBER: _____

ADDRESS: _____ CITY: _____

STATE: _____

ZIP: _____

How did you learn about Best Care Pet Hospital?

Yellow Pages  Personal Reference (Whom may we thank?) _____
OTHER:_____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment and agree to pay all fees and charges for such treatment. All charges are due upon request and/or release of patient. I further understand that any pet left at Best Care Pet Hospital for longer than 24 hours after the planned dismissal date will be deemed abandoned and disposed of at the discretion of hospital management. Any resulting additional charges will remain the responsibility of the owner and/pr responsible party.

SIGNATURE: _____

DATE: _____

It is our policy to provide you with an estimate of charges for any medical treatment, surgery, or hospitalization that will be provided, if requested. A deposit may be required prior to treatment. Full payment is required at time of service. We do not bill. Service fees are charged for returned checks. Any unpaid balance at the end of the month will incur interest of 1.5% per month (18.0% per year) and an account handling fee of $3.00. Any balance without payment after 90 days will be referred to a collections agency.