

NIPPERS CORNER PET MEDICAL CENTER

Client No: _____

Owner's Name: _____ Spouse/Other: _____
 Address: _____ City: _____ Zip: _____
 County: _____
 Home Phone: owner: _____ spouse/other: _____
 Business Phone: owner: _____ spouse/other: _____
 Cell Phone: owner _____ spouse/other: _____
 Driver License: owner _____ spouse/other: _____
 Date of Birth: owner _____ spouse/other: _____
 Email Address: owner _____ spouse/other: _____
 How did you hear about us? _____

PET INFORMATION

<i>Pet name</i>			
<i>Species</i>	Cat Dog	Cat Dog	Cat Dog
<i>Breed</i>			
<i>Color</i>			
<i>Hair length</i>			
<i>Date of birth</i>			
<i>Sex</i>	M F spay or neutered	M F spay or neutered	M F spay or neutered
<i>Any medications? If so, what.....</i>			
<i>Any known allergies? If so, what.....</i>			

MEDICAL HISTORY – *please check if your pet has had the following preventative health care services with the last year:*

Cats

Dogs

- | | | |
|---|--|--|
| <input type="checkbox"/> physical examination | <input type="checkbox"/> physical examination | <input type="checkbox"/> heartworm test |
| <input type="checkbox"/> FVRCP-C vaccination | <input type="checkbox"/> Distemper/Parvo vaccination | <input type="checkbox"/> on heartworm preventive |
| <input type="checkbox"/> Rabies vaccination | <input type="checkbox"/> Corona Virus vaccination | |
| <input type="checkbox"/> Leukemia vaccination | <input type="checkbox"/> Rabies vaccination | |
| <input type="checkbox"/> dental exam/cleaning | <input type="checkbox"/> Bordetella vaccination | |
| <input type="checkbox"/> FeIV/FIV Test | <input type="checkbox"/> internal parasite exam | |
| <input type="checkbox"/> internal parasite exam | <input type="checkbox"/> dental exam/cleaning | |

REASON FOR VISIT: _____

Method of payment: () cash () check () credit card () bank card () pet insurance

Payment in full is expected when treatment is performed or animal is discharged. In case of emergency hospitalization, deposit arrangements must be made with Dr. Torchia. On your request, we will provide you with a written estimate of fees before care is provided.

I understand and agreed that I am financially responsible for payment in full for all services and products received from and/or provided by *Nippers Corner Pet Medical Center*. I understand that should I fail to honor my financial obligations with this facility, the entire balance shall be considered in default and immediately become due and payable. In addition, I understand the costs of collection and reasonable attorney fees necessary to collect the full amount due will be added to the balance. All unpaid balances shall be assessed interest fees of 1.75% per month (21% per year) beginning on the date of the service.

Signature _____ Date _____