ANIMAL CARE CENTER & BEACHES PET RESORT

CLIENT NAME: ____
(LAST) (FIRST) (M.I.)

ADDRESS: ____
(STREET) (CITY) (STATE, ZIP)

TELEPHONE: _______________ (HOME)____________________X_____(WORK/CELL)
please circle

EMAIL ADDRESS: ____

D.L. # __________________________ S.S. # __________________ D.O.B.___________

PATIENT INFORMATION

	PET #1	PET #2	PET #3
PET NAME:			
SPECIES:			
BREED:			
D.O.B.:			
SEX:			
COLOR:			

MEDICAL/VACCINATION HISTORY

CLINIC NAME: ____

CLINIC PHONE or CITY/STATE: ____

VACCINES/DATE GIVEN: ____

IMPORTANT MEDICAL INFORMATION: ____

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WOULD YOU LIKE YOUR PET RESCUSITATED IN THE EVENT OF AN EMERGENCY? Yes □ No □

*****<u>**PAYMENT IS REQUIRED AT TIME OF SERVICE. WE ACCEPT CASH, MAJOR CREDIT CARDS AND CHECK WITH DRIVER'S LICENSE OR SOCIAL SECURITY INFORMATION.**</u> *****

I confirm that this information is true to the best of my knowledge and belief. I understand that I am responsible for payment for all services rendered, including reasonable attorney's fees and costs of collection in the event of default. Finance charges will be applied to all delinquent accounts after 30 days at an annual percentage rate of 18%.

As the owner of the above named animal(s) being treated at the Animal Medical Clinic of Panama City Beach, DBA Animal Care Center, I authorize the use of any or all therapeutic procedures determined to be necessary and understand that I am responsible for payment of same.

SIGNATURE: ________________________________ DATE: _____________

WE APPRECIATE YOUR TRUST AND CONFIDENCE IN THE CARE OF YOUR PET(S).

SCOTT D McLELLAND, DVM
CHARLES D SLEETH, DVM
RICHARD E SMITHERMAN, VMD
MATT T LeBLEU, DVM