

Welcome

Please Print and Complete All Information

CLIENT INFORMATION

Your Name _____ Spouse _____
Mailing Address _____ Home Phone(____) _____
City _____ State _____ Zip _____
Employer _____ Phone(____) _____
Whom may we thank for referring you? _____
Email Address (optional) _____

PET INFORMATION

Pet's Name _____ Dog Cat Male Female
Neutered/ Spayed Yes No Age/Birthdate _____ Breed _____
Color _____ Weight _____
Diet (kind of pet food) _____
Pet's History (check all that pet has received)
 Rabies (Dog/Cat) - Date _____ FVRCP - Date _____
 DHLPP-C (Distemper, Parvo, Corona) - Date _____ Feline Leukemia - Date _____
 Prior Illness _____

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PAYMENT

ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED, AND DEPOSITS ARE REQUIRED ON ALL HOSPITALIZED PATIENTS. To prevent the spread of infectious diseases, all hospitalized patients must be current on all vaccines and free from internal and external parasites. The signature below authorizes this level of preventative care and the appropriate charges will be assessed in the discharge invoice.

I will be paying by Cash Check Credit Card (VISA, MasterCard or Discovery)

Our check clearing service requires that we see and record the following information before accepting a check payment. There will be a \$20.00 charge on returned checks. If a check is returned, all future services on your account must be paid by cash or credit card.

Driver's License # _____ State _____ Exp. Date _____ SSN _____

SIGNATURE _____ Date _____