

CLIENT INFORMATION

Full Name: _____ Spouse/Co-Owner's Name: _____

Phone Number: _____ Spouse/Co-Owner's Phone: _____

Email: _____ Additional Phone (work, etc): _____

Address: _____ City: _____ State: _____ Zip: _____

Driver's License: _____ **OR** Social Security Number: _____ Date of Birth: _____****required to be kept on file for occurrences of non-payment****

Name of Additional Person/s to be listed on the account: _____

TREATMENT AUTHORIZATION and INFORMATION RELEASE

I hereby authorize Animal Health Clinic to perform medical and initial diagnostic/surgical procedures on this animal as required for diagnosis and treatment. I understand that I can terminate treatment at any time by contacting the doctors and assistants.

In the event that I sell/give this animal to another owner, I authorize the release of medical information to the new owner.

FINANCIAL POLICY**Payment is due at the time of service.**

For hospitalized/admitted cases, a deposit is required in advance. The balance is due upon discharge from the hospital. Payments can be made by cash, check and accepted credit cards, including Care Credit.

WE DO NOT DO PAYMENT PLANS.

The undersigned agrees to these terms. To avoid misunderstanding, please let us know immediately if these terms are not satisfactory.

I have read and accept the preceding obligations.

Owner(s) Signature: _____ Date: _____

	PET	PET	PET
NAME			
BREED			
DATE OF BIRTH/AGE			
COLOR			
SEX: M/F SPAYED/NEUTERED?			

YOUR DOG'S VACCINATION HISTORY

RABIES			
DISTEMPER/COMBO			
BORDETELLA (kennel cough)			
HEARTWORM TEST			

YOUR CAT'S VACCINATION HISTORY

RABIES			
FVRCP			
FELINE LEUKEMIA			
FELINE LEUKEMIA TEST			

During exam, please provide us information relating to previous illnesses/surgeries, allergies to vaccinations/medications, special diets, and current medications.