



Welcome

Client Information

Full payment is due at time services are rendered. Thank You.

*Please keep all copies of records given. If lost & we reprint, there will be a fee for supplies/ink usage.

Your Name _____ Senior Citizen 65 or older? YES NO

Spouse Name _____

Address _____ Cell & Name _____

City _____ State _____ Zip _____ Cell & Name _____

E-Mail Address _____

Please provide us with your email address so we can keep you up-to-date on client/pet reminders, clinic updates and other special events!

I understand that Animal Health Clinic may use a photo(s) of myself and/or my pet(s) on our Facebook page and/or clinic newsletter. We love to make our patients famous! Please initial if you give us permission or write NO if not.

Employer _____ Business Phone _____

Business Address _____ City _____ State _____ Zip _____

Drivers Lic. # _____ Exp Date _____ Owners Birthdate _____

Federal law requires us to report a driver's license number to the State of Michigan on controlled substance medications that we prescribe or use in clinic on your pet. The law also requires a MAPS report to be completed.

Type of payment: Cash Visa MasterCard American Express Discover Care Credit Check (We cannot accept checks from new clients)

How did you hear about us? Drive by Social Media Referral Google Website OTHER: _____

Whom may we thank for referring you? Client _____ Other _____

In case of an emergency please provide an alternate contact name _____ Phone _____

Pet Information

No.1 Pet's Name _____ Breed _____ Color _____ Sex _____ S or N DOB _____

No.2 Pet's Name _____ Breed _____ Color _____ Sex _____ S or N DOB _____

No.3 Pet's Name _____ Breed _____ Color _____ Sex _____ S or N DOB _____

I, the undersigned, give permission for Animal Health Clinic to share vaccine history/routine care to boarding/grooming facilities, rescue organizations, The Humane Society, Animal Control, Emergency and/or Referral Clinics.

CIRCLE: Yes No

Payments

ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. We accept all major credit cards. There will be a \$35 service charge for any check returned unpaid. 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 preventive care and acknowledges that the above information is correct.

I understand the above terms and contract and agree to pay in full. I further understand that if this account is not paid in full, it will be turned over to the appropriate collection agency or legal system. All fees including court, attorney, and collection costs will be applied to the collection of the delinquent account.

Signature of Client Responsible for Pet (s) _____ Date _____