

**CLIENT INFORMATION FORM**

Date:

Client #

Owner's Name:

Spouse's Name:

Owner's Address:

City:

State:

Zip Code:

Home Phone:

Cell Phone:

Work Phone:

Email Address:

Owner's Employer:

Owner's Drivers' License # or State ID#:

**Method of payment:**    Cash    Check    Visa/MC/Discover    Care Credit

***OUR PAYMENT POLICY: Payment is due in full at the time of service. An amount equal to 1/3 of your estimate is required if your pet is admitted to the hospital. Credit is extended through VISA, MASTERCARD, DISCOVER and CARE CREDIT. We do not accept insurance as payment. The client is responsible for submitting claims to their insurer for reimbursement. \*\*Please acknowledge our policy by signing on the line below.***

X \_\_\_\_\_ Date: \_\_\_\_\_

Pet's Name:

Dog  Cat  Other  \_\_\_\_\_

Date of Birth/Age:

Sex:  Male    Female    Neutered/Spayed

Breed:

Color:

Date of last vaccination:

Type of last vaccination:

Date of last heartworm test:

Pet is:  Indoors    Outdoors    Both

How did you find out about our hospital? Please check all that apply:

 Referred by a friend/relative Name of referrer: Phone book: Location/saw sign: Website: Other (please specify):

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Dog  Cat  Other  \_\_\_\_\_

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