

Patient Information Sheet (PLEASE PRINT)

OWNER:

Last Name _____ First Name _____

Spouse/Co-Owner

Last Name _____ First Name _____

Address(street) _____ (apt#) _____

(city) _____ (state) _____ (zip) _____

Phone #s: Home _____ Cell _____ Spouse/Co-Owner Cell _____

Please circle which phone # that you would like to be the primary # we call

Employment: Owner _____ Work # _____

Spouse/Co-Owner _____ Work # _____

Email: _____

Form of Payment: (1) Check--Driver's License # required _____

(2) Cash

(3) Charge card--MC, Visa, Discover or Care Credit

The undersigned agrees that all past due amounts shall be charged 1.75% interest per month (\$5.00 minimum) on the unpaid balance commencing thirty (30) days after billing. The undersigned accepts full financial responsibility and agrees to notify this office within 10 days of any change of address. The undersigned assumes and agrees to pay for all collection agency fees paid or incurred by us. Collection agency fees can be up to an additional 50% of the amount turned over for collection. In the course of collection of the amount due, an attorney may be engaged by this office or by the collection agency to help with the collection. The undersigned agrees to pay reasonable attorney fees, court costs, and other costs paid or incurred by this office or our collection agency while collecting the amount due.

OWNER/CO-OWNER SIGNATURE _____ DATE _____

PET:

Name _____ Age _____ Sex _____ Neutered/Spayed yes or no

Breed _____ Color _____ Warnings to vet _____

Vaccination status: Cat---FVRCP _____ FELV _____ Rabies _____ FIP _____

(date last given) FIV test _____ FELV test _____ Fecal test _____

Dog---DHLPPC _____ Rabies _____ Bordetella _____

Lyme _____ Heartworm test _____ Fecal test _____

Is your pet on Heartworm Preventative & what kind? _____

Is your pet on Flea Preventative & what kind? _____

Does your pet have any major medical/social problems that we need to know about? _____

Would you be interested in pet health insurance for your pet? Yes or No

Please tell us how you were referred to our clinic so we may thank them: _____