CLIENT INFORMATION

OWNER'S NAME:____ SPOUSE/OTHER:________________________
ADDRESS____
CITY________________________ STATE__________ ZIP____________ COUNTY__________________________
PHONE NUMBER: ______________________________ ALTERNATE NUMBER: _____________________________
EMAIL ADDRESS (FOR REMINDERS)____

CLIENT'S EMPLOYER____
ADDRESS____
CITY______________________ STATE_____________ ZIP___________ COUNTY__________________________

SPOUSE'S EMPLOYER____
ADDRESS____
CITY_____________________ STATE_____________ ZIP____________ COUNTY__________________________

DRIVER'S LICENSE NUMBER________________________ STATE____________

CLIENT'S SOCIAL SECURITY NUMBER____________________________________

HOW DID YOU HEAR ABOUT OUR HOSPITAL?
REFERRAL______ SOMEONE WE MAY THANK__________________________________
SIGN______ WEBSITE____
OTHER____

IN ORDER TO PREVENT THE SPREAD OF INFECTION, DISEASES, AND PARASITES, **ALL HOSPITALIZED AND BOARDING** ANIMALS MUST BE CURRENT ON ALL VACCINES AND FREE OF INTERNAL AND EXTERNAL PARASITES. I AUTHORIZE THE DOCTOR TO PROVIDE VACCINATIONS AND PARASITE CONTROL AS NEEDED FOR MY PET.
INITIAL________

<u>PAYMENT IS DUE WHEN SERVICES ARE RENDERED.</u> A CHECK HANDLING FEE OF $30.00 WILL BE CHARGED FOR ALL RETURNED CHECKS. AFTER 30 DAYS, ANY UNPAID CHARGES ON ACCOUNT WILL BE REFERRED TO OUR COLLECTION AGENCY. COLLECTION AGENCY AND ATTORNEY FEES WILL BE ADDED TO THE ACCOUNT. ARRANGEMENTS WILL BE MADE FOR ANY PET DEEMED ABANDONED ACCORDING TO STATE LAWS.

SIGNATURE____ DATE______________________

THANK YOU FOR GIVING US THE OPPORTUNITY TO CARE FOR YOUR PET!! **<u>PLEASE PROVIDE INFORMATION ABOUT YOUR PET(S) ON THE OTHER SIDE OF THIS FORM.</u>**