WELCOME TO OUR PRACTICE

**PLEASE PRINT IN ALL SPACES**

OWNER ______________________________ SPOUSE/OTHER ______________

ADDRESS ____________________ CITY ___________ STATE______ZIP ______

HOME PHONE ____________________________ SOC. SEC # ______________

EMPLOYER ______________________________ WORK PHONE______________

SPOUSE/OTHER EMPLOYER___________________ WORK PHONE______________

CELL PHONE ____________________________ CELL PHONE______________

EMERGENCY CONTACT ______________________ PHONE ______________

E-MAIL ADDRESS ___________________________

| Equine | Cat | Dog | Pet's Name | Date of Birth | Sex | Spayed or Neutered | Breed | Color |
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All professional fees are due at the time services are rendered. In cases of extensive medical or surgical procedures, when full payment may be difficult at discharge, we take MasterCard, Visa, Discover, Care Credit, or you can establish a payment arrangement, if approved in advance of treatment. There will be a $20.00 service charge for any check returned unpaid. If the service of an outside agency is required for collection of this account, I agree to pay costs of collection including but not limited to Collection Agency Fees, Attorney Fees, Interest and Court Costs. Your signature below maintains that you are authorized to present animal(s) for treatment, surgery, diagnostics, and/or euthanasia.

Signature of Responsible Party for Pet(s)______________________ Date ______________

In addition to the current signatory, please list any other individuals who are authorized to present animal(s) for treatment in the future.

Names of other authorized signatories:______________________

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