

Receptionist: _____

Client Account #: _____

Client Data Form

Client Registration:

Thank you for choosing our animal clinic. We pride ourselves in offering high quality medical care and emphasize preventative medicine. We look forward to serving you and caring for your pet's needs for many years to come. Please complete this form so we can accurately enter this information into our files. To open an account with us you must be at least age 18 and provide a photo ID, such as driver's license and your social security number.

Owner Information:

Name: _____ Date of Birth: _____

Current Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Ways you can be reached:

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

How would you like to be contacted: Phone ___ **Text message** ___ **Email** ___

The following information is required for your account and is strictly

CONFIDENTIAL:

S.S #: _____ Driver's License # _____

Second Contact Information:

Name: _____ Relation to you: _____

Cell Phone: _____

Receptionist: _____

Client Account #: _____

AUTHORIZATION FOR PROFESSIONAL SERVICES

I hereby authorize the Animal Health Clinic to perform such diagnostic, therapeutic and surgical procedures as are, in their opinion, necessary and advisable for treatment and maintenance of my pet's health and wellbeing. The nature of such services has been described to me to my satisfaction and, while I expect all procedures to be done to the best of the abilities of the professional staff, I realize that neither guarantee nor warranty can ethically or professionally be made regarding the results or cure.

I also authorize the hospital director and staff to provide veterinary service as required or in emergency circumstances to follow through with such procedures as are necessary for the wellbeing of my pet on a continuing basis until further advised in writing.

I understand that I assume responsibility of all fees, and that they are due, at time services are rendered. Please feel free to ask for an Estimate prior to providing services. If at anytime you are not satisfied with our service, please let us know. We will be happy to answer your questions.

How do you plan to pay for today's services? Circle one: Cash Check Credit/Debit
Payment is due in full at the time of service. We offer **Care Credit** if you need a payment plan.

Agreement Terms: Balances due over 30 days will be charged 1% monthly interest charge (18% APR). Checks returned for non-sufficient funds will be charged \$40.00 and may be debited from your bank account electronically. Additional collection fees will be charged if your past-due account is sent to Biorn Collections.

Signature of Responsible Party

Date

Receptionist: _____

Client Account #: _____

Patient (Pet) Information

Pet # 1 Name: _____ Breed: _____

Date of Birth: _____ Age: _____ Color: _____

Sex: _____ Spayed or Neutered: _____ Microchip #: _____

Date of last vaccination & where: _____

Is your pet covered by Pet Insurance? **Yes No** (If yes, please provide documentation)

Pet # 2 Name: _____ Breed: _____

Date of Birth: _____ Age: _____ Color: _____

Sex: _____ Spayed or Neutered: _____ Microchip #: _____

Date of last vaccination & where: _____

Is your pet covered by Pet Insurance? **Yes No** (If yes, please provide documentation)

Pet # 3 Name: _____ Breed: _____

Date of Birth: _____ Age: _____ Color: _____

Sex: _____ Spayed or Neutered: _____ Microchip #: _____

Date of last vaccination & where: _____

Is your pet covered by Pet Insurance? **Yes No** (If yes, please provide documentation)

Pet # 4 Name: _____ Breed: _____

Date of Birth: _____ Age: _____ Color: _____

Sex: _____ Spayed or Neutered: _____ Microchip #: _____

Date of last vaccination & where: _____

Is your pet covered by Pet Insurance? **Yes No** (If yes, please provide documentation)
