New Client/Pet Information

Owner's Name_____Phone_____
Address_____City_____State_____ Zip_____
E-mail address_____ Social Security Number_____
Driver's License #_____ STATE _____ EXP._____
How did you hear about our clinic?:_____

Name of Pet #1:_____ Male / Female (circle one)
Spayed/Neutered/Intact (circle one)
Dog/Cat/Rabbit/Bird/Ferret/Reptile/Rodent/Fish/other
Breed:_____Color:_____Species(if exotic)_____
Microchip Number:_____
Birth Date/Age:_____
Vaccination History (provide dates if known)
Distemper_____Rabies_____Leukemia_____Bordetella_____Heartworm Test_____

Name of Pet #2:_____ Male / Female (circle one)
Spayed/Neutered/Intact (circle one)
Dog/Cat/Rabbit/Bird/Ferret/Reptile/Rodent/Fish/other
Breed:_____Color:_____Species(if exotic)_____
Microchip Number:_____
Birth Date/Age:_____
Vaccination History (provide dates if known)
Distemper_____Rabies_____Leukemia_____Bordetella_____Heartworm Test_____

Name of Pet #3:_____ Male / Female (circle one)
Spayed/Neutered/Intact (circle one)
Dog/Cat/Rabbit/Bird/Ferret/Reptile/Rodent/Fish/other
Breed:_____Color:_____Species(if exotic)_____
Microchip Number:_____
Birth Date/Age:_____
Vaccination History (provide dates if known)
Distemper_____Rabies_____Leukemia_____Bordetella_____Heartworm Test_____

**** PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED ****
We accept cash, in-state checks, Visa, Mastercard, and Care Credit.

I, the undersigned owner or authorized agent of the above admitted patient, hereby authorize the doctors of Country Club Veterinary Clinic to administer such treatment as is necessary and to perform procedures therapeutically and/or diagnostically. I further understand that no guarantee of successful treatment is made. I also assume financial responsibility for all charges incurred, and agree to pay all such charges at the time of release. I understand that unpaid balances over 30 days are subject to a **monthly 1.5% (18% APY) finance charge**. Any balance that I leave unpaid will be forwarded to our collection agency, and will incur a **25% collection fee** for which I am liable, in addition to monthly finance charges. There will be a **$35 fee** charged for any check that is returned. At your request we will gladly discuss cost of services and/or prepare a written estimate of recommended procedures/treatments. **Deposits may be required for pets being admitted into the hospital.**

_____
Signature of owner/agent Print Name Date

_____
Signature of Witness Print Name Date