New Client Information

Client # (office use only): __________ Date: _________

Name:____

Address:____

City:______________ State:____ ZIP:_________

Home #:________________ Cell #:___________________

Work #:_____________Email:_________________________

Place of Employment:__________________

Date of Birth:___________ Driver's License Number:__________________

Spouse's Information:

Name:________________________ Cell #:_____________ Work #:____________

Place of Employment:_____________________ Date of Birth:__________

Driver's License Number:__________________

All Fees Are Due at Time of Service Rendered

Please indicate choice of payment: Cash__ Check__ Credit Card__

Pet Information	Pet #1	Pet #2
Name		
Breed		
Date of Birth		
Color		
Male or Female		
Spayed or Neutered		

How did you become aware of our clinic: Drove by___ Google___ Previous client___

Personal Referral (who may we thank?)____________________ Other___________________________

A $27.50 bank fee will be added to your account for all returned checks due to insufficient funds. Additional billing and collection fees will apply when necessary.

I certify that I have carefully read the returned check policy and understand it before signing below:

Name (printed):_____________________________ Signature:______________________________