

ANIMAL CLINIC OF EAST AVENUE

Client Information

Owner Information:
Information:

(Owner must be at least 18 years old)

Name: _____

Address: _____

Co-Owner/Emergency Contact

(Please add address/phone **if different**)

Name: _____

Address: _____

Phone: (____) _____ Text: Y or N Phone: (____) _____ Text: Y or N

Cell Phone: (____) _____ Text: Y or N

Driver's License #: _____ - _____ - _____ (if writing a check)

Employer: _____

Work Phone: _____

Email Address: _____

Would you like to receive your pets reminders by e-mail? Y or N

Patient Information

Name: _____

DOB: _____

Species: _____ Breed: _____ Color: _____

Gender: _____ Please circle one: Intact / Fixed

Habitat: Indoor to Outdoor Ratio: (Please Circle One Below)

100% indoor only for walks & bathroom 50% to 50%

only when cold 100% outdoor

What Other Pets are at home? _____

What type of food is your pet on? Canned _____ Dry _____ Both _____

Brand of food _____ Amount per day _____

Any Table scraps? _____ If yes, how often? _____

Any treats? (rawhides, bones, pig or cow ears) _____ If yes, how often? _____

Where did you get your pet? _____ When? _____

When was the last time your pet was examined by a veterinarian? _____

Is your pet being treated for any medical problems? _____

Does your pet have any known allergies? _____ If yes, please describe _____

Any previous vaccines? _____ If yes, Which Hospital? _____

Whom may we thank for referring you? _____

Payment Policies:

*** FULL PAYMENT IS EXPECTED AT TIME OF

SERVICE****

If there remains a balance that cannot be collected at time of service, I understand that it will be subject to the billing policies of the Animal Clinic of East Avenue. This includes balances subject to 10% interest every month and billing charges until a balance is > 3 months and then balance will be subject to a 15% interest charge. Account past due > 3 months will be sent to collections. Late fees will apply to accounts without monthly payments of > 10% of the balance. All fees associated with the collection process, including but not limited to: agency fees, attorney fees, and court costs will become the responsibility of the delinquent party. Any check returned unpaid will incur a \$25.00 fee. After 2 checks have been returned unpaid, payment must be in form of cash, money order or credit card. A charge may be assessed for appointments cancelled without at least 24 hours notice.

****I acknowledge that I have read, understand and agree to the above listed payment policies. In addition, I agree that accepting service and/or merchandise offered by the Animal Clinic of East Ave.,**

**** I acknowledge and understand acceptance of use of any photographic images are the property of Animal Clinic of East Avenue for representation of company for internet, digital or local representation.**

Form of payment: Cash Check (with drivers license) Visa/MC/AmEx
 Discover CareCredit

SIGNATURE: _____ **DATE:** ____/____/____
____staff initial_____