CLIENT INFORMATION (Please Print)

OWNER: _____CO-OWNER:_____

ADDRESS:_____CITY: _____STATE:____ ZIP:_____

BEST CONTACT # TO KEEP ON FILE: _____ E-MAIL:_____

WORKPLACE:_____WORK PHONE:_____

CO-OWNER WORKPLACE:_____WORK PHONE:_____

EMERGENCY CONTACT & NUMBER: _____

REFERRED BY: _____PREVIOUS VETERINARIAN:_____

PATIENT INFORMATION

PET NAME(S)					
SPECIES (Dog, Cat, etc.)					
BREED					
COLOR / MARKINGS					
AGE OR BIRTHDATE					
SEX /NEUTERED Yes/No					

OFFICE USE…….. INFORMATION VERIFIED...									

PAYMENT POLICY

It is our policy to provide you with a written estimate of fees, for any case where in-hospital treatment or emergency care is necessary. A 50% deposit of the estimated fee is required prior to treatment. Routine/ elective procedures are payable at the time of service. Master, Visa, Discover & Care Credit are accepted for your convenience.

I AGREE TO PAY FEES FOR SERVICES IN FULL AT THE TIME OF THE PET(S) DISCHARGE FROM THE HOSPITAL OR WHEN SERVICES ARE OTHERWISE TERMINATED. IN THE EVENT OF A NON-PAYMENT; I AGREE TO REIMBURSE DUMFRIES ANIMAL HOSPITAL THE FEES OF ANY COLLECTION AGENCY, WHICH MAY BE BASED ON A PERCENTAGE AT A MAXIMUM OF 33% OF THE DEBT, AND ALL COSTS, AND EXPENSES, INCLUDING REASONABLE ATTORNEYS' FEES, WE INCUR IN SUCH COLLECTION EFFORTS.

SIGNATURE: _____DATE: _____

DRIVERS LICENSE#: _____STATE: _____

(Drivers License ID is required for check payments)