Client Registration

Client Name: ____
Last First Middle

Address: ____
Street City State Zip

Home Telephone: (_______)_____________Work Telephone: (_______)____________________

Cell phone or Beeper: (_______)_____________ Employer: ____________________________

Employer's
Address: ____
Street City State Zip

Drivers License Number: _________________________ Date of Birth: ____________________

E-Mail Address: ___________________________________

If you would like to receive reminders by E-mail please supply your address.

Spouse's Name: ____
Last First Middle

Address:____
Street City State Zip

Home Telephone: (_____)_______________ Work Telephone: (_____)______________________

Cell phone or Beeper: (______________________ Spouse's Employer: ____________________

Employer's
Address: ____
Street City State Zip

Drivers License Number: _________________________ Date of Birth: ____________________

Spouse's E-Mail Address: ___________________________________

If you would like to receive reminders by E-mail please supply your address.

Person to contact in case of emergency (third party):____________________________________

Address: ____
Street City State Zip

Home Telephone: (____)_______________ Work Telephone: (____)_______________________

Cell phone or Beeper: (____)_____________________

Name of person or source that referred you: ____

Patient Registration

Pet's name: ___________________________ Breed: ____________________________________

Microchip or Tattoo Number: ____________________________
Date born: ____________________________ Color: ___________________ Sex: ____________
Spay/Neuter

History of any previous surgery, treatments, or medications: _______________________________
____
____

Name of Previous Veterinarian: ____
Address or Phone Number with Area Code, if possible

Dates of Last Vaccinations:

Canine:

Distemper – Hepatitis – Parinfluenza - Parvo – Corona: ____________1 – year or 3 – year
Leptospirosis: ________________________
Bordetella: __________________________
Rabies: _____________ 1 – year or 3 – year
Fecal Exam: _________________________
Last Heartworm Check: ________________

Feline:

Feline Distemper/ Upper Respiratory Vaccine: _________1 – year or 3 – year
Feline Leukemia Test: ______________
Feline Leukemia: __________________
Rabies: __________ 1 – year or 3 - year
Fecal Exam: ______________________

If animal is hospitalized, do you authorize any necessary treatments without contacting you?
YES **NO** Please Circle one

PAYMENT POLICY FOR SERVICES RENDERED

For your convenience, we accept cash, checks, Visa, Master Card, Discover, American Express and debit cards. We will be happy to discuss any fees with you before your appointment or give you an estimate at any time for services. It is our policy to charge $25.00 for any returned checks. There will be a finance charge applied to all accounts unpaid after 30 days. Finance charge is computed by a periodic rate of 1.50% per month, which is the annual percentage rate of 18.00%. There is a minimum finance charge of $9.00 per month.

FINANCIAL RESPONSIBILITY AGREEMENT

I, the undersigned, understand and acknowledge that if an account balance is not paid in a timely fashion, I will be responsible not only for the balance due but any collection and/or reasonable attorney fees that are incurred in the collection process. I understand that Great Falls Veterinary Clinic Inc. reserves the right to add an additional twenty-five to fifty percent fee if my account is sent to outside credit collections and that the Great Falls Veterinary Clinic Inc. will report delinquent accounts to all credit reporting agencies.

I have read the Payment Policy and the Financial Responsibility Agreement and understand its contents.

______________________________ ______________________________
Print Name Signature

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Date