



Welcome to our clinic



We are glad to have the opportunity to care for your pet

Client information:

Client ID#: _____

Owner's Name: _____ Spouse/Co-owner: _____

Address: _____

City: _____ State: _____ Zip: _____ e-mail: _____

How would you like to receive notifications when your pet is due? Mail e-mail

Would you like to receive quarterly newsletters and information about special offers via e-mail? Yes No, thanks
Atlantic Veterinary Services will not share your e-mail address with any outside agencies.

Street Address (if different from above): _____

Phone: Home: _____ Cell: _____ Work: _____

Best time of day and number to call: _____ Emergency contact (name & phone): _____

How were you referred to our practice? _____

Patient information:

Pet's Name: _____ Canine Feline Other _____ Breed: _____

Color: _____ Date of Birth: ___/___/___ Sex: Male Female Spayed/Neutered? Yes No

Pet's Name: _____ Canine Feline Other _____ Breed: _____

Color: _____ Date of Birth: ___/___/___ Sex: Male Female Spayed/Neutered? Yes No

Pet's Name: _____ Canine Feline Other _____ Breed: _____

Color: _____ Date of Birth: ___/___/___ Sex: Male Female Spayed/Neutered? Yes No

I HEREBY AUTHORIZE THE VETERINARIAN TO EXAMINE AND TREAT THE ABOVE DESCRIBED PATIENT(S) (ANIMALS). I ASSUME FINANCIAL RESPONSIBILITY FOR ALL CHARGES INCURRED IN THE CARE OF THIS/THESE ANIMALS. THIS INCLUDES LEGAL, FINANCE AND COLLECTION CHARGES. UNPAID BALANCES ARE SUBJECT TO REASONABLE FEES OF AT LEAST 15% FOR ATTORNEY FEE, 35% COLLECTION FEE, 2.0% FINANCE FEE AND \$3.00 END OF MONTH CHARGE. I ALSO UNDERSTAND THAT THESE CHARGES WILL BE PAID, IN FULL, AT THE TIME OF SERVICE, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Method of payment for today's services: Cash Visa MasterCard

****IF YOU WOULD LIKE TO MAKE FUTURE PAYMENTS WITH A PERSONAL CHECK, THEN PLEASE PROVIDE THE FOLLOWING INFORMATION:**

Driver's License number: _____ Social Security Number: _____

PLEASE NOTE: Atlantic Veterinary Services is not open, and is not staffed, 24 hours.

**PATIENTS WITH FLEA, TICK, OR OTHER PARASITE INFESTATIONS WILL BE TREATED, AT AN ADDITIONAL EXPENSE, TO PROTECT OTHER PATIENTS AND TO HELP CONTROL PARASITE PROBLEMS.

SIGNATURE OF OWNER OR AGENT: _____

DATE: ___/___/___