VETERINARY MEDICAL CENTER
of Easton

NEW CLIENT FORM

Thank you for giving us the opportunity to care for your pet(s).
So that we may become better acquainted, please complete the following:

CLIENT INFORMATION Date _____

Name _____ Spouse's Name _____

Address _____ City _____ State _____ Zip _____

Phone_____ Work Phone _____ Cell Phone_____

Spouse's Work Phone _____ Spouse's Cell Phone_____

Place Of Employment _____ Best Time To Reach You _____

E-Mail Address _____

In case we can not reach you regarding your animal, we need information on a close friend or relative.

Name_____ Relationship_____ Phone#_____

Do they have permission to make medical decisions on your behalf?_____

All Fees Are Due At The Time Services Are Rendered

Please indicate choice of payment. ___ Cash / Check ___ Visa ___ MasterCard

How did you become aware of our clinic? ___ Drove by ___ Yellow Pages ___ Newspaper Ad

___ Website Specify_____ ___ Other _____

___ Personal Recommendation *(Whom may we thank?)* _____

	PET # 1	PET # 2	PET # 3
NAME			
BREED			
DATE OF BIRTH			
COLOR			
SEX; SPAYED OR NEUTERED?			

Our pet(s) is: ___ Member of our family ___ Child's pet ___ Backyard pet

Any previous serious illnesses or surgeries? _____

Any allergies to vaccinations or medications? _____

If your pet has previously been seen by another veterinarian, please provide pertinent records so that we may have all necessary information regarding your pet(s).

Previous Veterinarian _____ Phone#_____

Accounts unpaid after 30 days are subject to a finance charge of 1.50% per month, (annual percentage rate 18.00%); minimum charge of $1.00. If your account is placed for collection, you will be liable for all costs of such collection, including but not limited to attorney's fees and court costs.

I HAVE READ THE ABOVE AND UNDERSTAND THE FINANCE CHARGE.

_____ _____
Signature Date

THANK YOU FOR CHOOSING VETERINARY MEDICAL CENTER!

Revised: _____ 200__ / _____ 201__ / _____ 201__