

CLIENT INFORMATION

**Owner:** Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Spouse: \_\_\_\_\_

Owner D.O.B \_\_\_\_\_ DL # \_\_\_\_\_ Spouse D.O.B. \_\_\_\_\_ DL # \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Spouse Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Spouse: \_\_\_\_\_

How Did You Hear About Our Clinic? \_\_\_\_\_

Email Address: \_\_\_\_\_

**Pet Information**

Name: \_\_\_\_\_ Breed: \_\_\_\_\_ Color: \_\_\_\_\_

D.O.B. \_\_\_\_\_ Sex: \_\_\_\_\_ Spayed/Neutered ? \_\_\_\_\_

Microchip #: \_\_\_\_\_ Tattoo: \_\_\_\_\_

Enter the most recent dates for the following health procedures ( If vaccinated at another clinic) :

Rabies: \_\_\_\_\_ DHP PV: \_\_\_\_\_ Kennel Cough /Bordetella: \_\_\_\_\_

Heartworm Check: \_\_\_\_\_ Fecal: \_\_\_\_\_ FVRCP: \_\_\_\_\_ FELV: \_\_\_\_\_

Reason For Visit: \_\_\_\_\_

If vaccinations were not given at this clinic we do require proof of vaccinations

\_\_\_\_\_

I understand that I am financially responsible for the total charges for services rendered. I agree to pay in full for services rendered, including those deemed necessary for medical and/or surgical complications or unforeseen circumstances. Any estimate of charges for presently planned procedures is only an approximation and the final bill may be greater or less than this amount and made payable to RCVC. I am aware that a deposit may be required at the time of admission for surgical, drop off examinations, boarding, and emergencies.

The duration of this authorization is indefinite and continues until revoked in writing. I am responsible for payment of services in full. I further understand should my account become delinquent; I shall pay the reasonable attorney's fees or collection fees, If any.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date