3449 DELTONA BOULEVARD
SPRING HILL, FLORIDA 34606

Welcome to the Animal Medical Clinic!

Please tell us about you and your family:

Name _____
LAST FIRST SPOUSE

Address _____
STREET CITY ZIP

Phone: (Home) _____ (Cell) _____ (Work) _____

Employer _____ Email Address _____

Need Copy of Driver License SS#: _____
(Requested Not Required)

How did you first hear about us? _____

Please tell us about your pet:

Pet's Name _____

What kind of pet? (Circle One) Dog Cat Allergies: _____

Breed: _____ Color: _____

Neutered? Yes No Sex _____ Birth Date? (or Estimated Age) _____

Prescription Medications: _____

Financial Policy

ALL PAYMENTS ARE DUE AT TIME OF SERVICE, WE <u>DO NOT</u> DO PAYMENT PLANS OR TAKE POST DATED CHECKS.

Personal Checks: The Animal Medical Clinic reserves the right to refuse to accept a personal check any new client.

Returned Checks: There will be a fee (currently $20.00) for any checks returned by the Bank. If payment is not received on a returned check, we have the right to refuse future services and/or request alternative payment method.

I hereby authorize the staff of Animal Medical Clinic to examine and treat the above described animal. I understand that payment for services rendered is required at the time the animal is discharged from the clinic.

How will you be paying today? MC/VISA AMX/DISC CASH DEBIT CARE CREDIT

Signature of Owner: _____ Date _____