CLIENT # _____ (OFFICE USE ONLY)

Statesboro Bulloch Regional Veterinary Hospital

WE KNOW YOUR PET'S HEATH IS IMPORTANT AND WE THANK YOU FOR TRUSTING US TO CARE FOR THEM. TO HELP US PROVIDE THE BEST CARE POSSIBLE, PLEASE TAKE A FEW MOMENTS TO FILL OUT THIS FORM COMPLETELY. THANK YOU!

NAME OF PET OWNER _____
LAST FIRST MI SPOUSE

SS# OR DL#/STATE _____ CELL PHONE # _____

MAILING ADDRESS _____
NUMBER STREET APT CITY STATE ZIP

EMAIL ADDRESS _____ SPOUSE INFORMATION

YOUR EMPLOYER _____ SPOUSE EMPLOYER _____

WORK PHONE _____ SPOUSE WORK PHONE _____

ADDITIONAL PHONE _____ SPOUSE CELL PHONE _____

HOW DID YOU LEARN ABOUT OUR CLINIC? _____

**PET HEALTH HISTORY**

NAME OF PET _____ ◯ DOG ◯ CAT ◯ OTHER _____

BREED _____ COLOR _____ BIRTHDATE/AGE _____

◯ MALE INTACT ◯ MALE NEUTERED ◯ FEMALE INTACT ◯ FEMALE SPAYED

VACCINE HISTORY (IF NOT AT THIS CLINIC) _____

_____

REASON FOR VISIT _____

**AUTHORIZATION**

I HEREBY AUTHORIZE THE VETERINARIAN TO EXAMINE, PRESCRIBE FOR, AND/OR TREAT MY PET(S). I ASSUME FULL RESPONSIBILITY FOR ALL CHARGES INCURRED FOR THE CARE OF ALL MY PETS ON MY FILE. I ALSO UNDERSTAND THAT THESE CHARGES WILL BE PAID AT THE TIME OF RELEASE AND THAT A DEPOSIT MAY BE REQUIRED FOR SURGICAL TREATMENT OR HOSPITALIZATION. I ALSO UNDERSTAND AND AGREE TO A $3.50 MONTHLY BILLING CHARGE, 1.5% MONTHLY FINANCE CHARGE AND RESPONSIBILITY FOR ANY COLLECTION CHARGES FOR A BALANCE DUE FOR ANY REASON.

**SIGNATURE** _____ DATE _____

METHOD OF PAYMENT: ◯ AMEX ◯ CARE CREDIT ◯ CASH ◯ DISCOVER ◯ MASTERCARD ◯ VISA ◯ SCRATCHPAY