DATE _____ NUMBER _____

CLIENT INFORMATION

OWNER'S NAME AND ADDRESS	MR. MRS. MISS DR.			
	LAST	FIRST	MIDDLE	HOME PHONE
	STREET	CITY	STATE	ZIP
EMPLOYER'S NAME AND ADDRESS	NAME	BUSINESS PHONE	OWNER'S SOCIAL SECURITY NO.	
	STREET	CITY	STATE	ZIP
SPOUSE	NAME	EMPLOYER		

ANIMAL INFORMATION

DOG	CAT		NAME	BREED	DESCRIPTION	DATE OF BIRTH	SEX	ALTERED	WT.	DATE OF LAST IMMUNIZATION OR EXAMINATION				
										D-H-L	R	FDRT	HEARTWORM EXAM	

PLEASE CIRCLE FORM OF PAYMENT DESIRED

1. — CASH

2. — CHECK
   NAME OF BANK _____
   ACCOUNT NO. _____

3. — MASTERCHARGE
   ACCOUNT NO. _____

4. — VISA
   ACCOUNT NO. _____

2. — OTHER _____

_____

_____

DUE TO RISING OPERATIONAL COSTS, WE HAVE ESTABLISHED THE FOLLOWING POLICY.

CASH PAYMENT AT TIME OF SERVICE RENDERED

MASTER CHARGE VISA PERSONAL CHECKS

ACCEPTED

REFERRED BY _____ DATE _____

Authorization to Release Veterinary Records

Pet Owner Information:

Name:_____

Address: _____

Telephone: _____

City: _____ State: _____ Zip Code: _____

E-Mail address: _____

Pet Information:

Name: _____ Breed: _____

Name: _____ Breed: _____

Name: _____ Breed: _____

The information released includes:

___Entire medical record ___ Vaccination history only ___ Current vaccination status only

Ceglinski Animal Clinic will provide the information requested above to the following:

1) Veterinarian 2) Boarding Facility 3) Groomer 4) Trainer 5) Other (mark out any that do not apply).

I hereby certify that I am the owner of authorized agent of the owner of the above describes pet (s). Further, I hereby request and authorized Ceglinski Animal Clinic to release the requested and their veterinarians and staff from any and all legal liability for the release of information to the extent indicated and authorized herein. I may revoke this authorization in writing at any time. The Ceglinski Animal Clinic policy is to provide the requested release within two business days of the written request.

X _____Date: _____

Owner or Owner's Agent Signature

Notice

I, _____ understand that payment is due when services are rendered.
(Client Name)

On occasion bills will be sent after the patient has been dismissed. If you do receive a bill, it must be paid within 30 days of the billing date. Failure to do so may result in the account being sent to collections.

Signature: _____ Date _____

Furthermore, if full payment is not received within 90 days of the billing date, the account will be turned over to collections. Client agrees to pay all cost of collection including attorney fees, collection fees, and contingent fees to collection agencies of not less than 40%. Such contingency fees will be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency.

Signature: _____ Date _____

Address: _____

_____

Phone Number: _____