

Franklin County Animal Medical Center
921 W 14th Street
Washington, MO 63090

NEW CLIENT FORM

Thank you for choosing Franklin County Animal Medical Center for the health care of your animals. Please fill out the following form so that we may learn more about you and your pet.

Date: _____

CLIENT INFORMATION

Name: _____ Spouse's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Place of Employment: _____

Date of Birth: _____ SSN or Drivers License#: _____

How did you become aware of our clinic? Drove by Yellow Pages Internet

Referred by a Friend If so, please tell us who so we know who to thank. _____

PATIENT INFORMATION

Name: _____ Breed: _____ Date of Birth or Age: _____

Color: _____ Sex: Male or Female Spayed or Neutered

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Color: _____ Sex: Male or Female Spayed or Neutered

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

Any previous serious illnesses or surgeries? _____

Any allergies to vaccinations or medications? _____

Is your pet on any special diets or medications? _____

Financial Policies/Collection and Late Fees

*Fees for services and dispensed medications or diets are required at the completion of said services or times of purchase.

*Acceptable methods of payment include: cash, check, credit card (Visa, MasterCard, Discover, American Express, Care Credit)

A finance charge of 20% annually will be applied to any unpaid balance thirty (30) days after the date of service is rendered or thirty (30) days after your insurance company has been paid.

This signature is on file as my authorization for the release of information necessary to process any claim or collection attempts. I hereby authorize payment directly to Franklin County Animal Medical Center.

I have read the above financial policy and agree to the terms outlined therein.

Signature

Date