ADAIR COUNTY VETERINARY CLINIC

NEW CLIENT/PATIENT INFORMATION

Owner' Name_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

E-Mail_____

Pet #1	**Pet #2**
Name_____	Name_____
Breed_____	Breed_____
Color_____	Color_____
Sex_____ Spayed Neutered	Sex_____ Spayed Neutered
Age or Birth Date_____	Age or Birth Date_____

Reason For Today's Visit_____

Method Of Payment: Cash____ Personal Check____ Bank Card____

PLEASE INQUIRE ABOUT THE COST OF SERVICES AS PAYMENT IN FULL IS REQUIRED AT THE TIME SERVICES ARE RENDERED. **WE DO NOT BILL**. IN SOME CASES A DEPOSIT MAY BE REQUIRED PRIOR TO TREATING YOUR PET.

I have read the above and hereby authorize the veterinarian and/or staff to examine, prescribe for, or treat the above described pet (s). I also assume full financial responsibility for any costs incurred and agree to pay such charges at the time services are rendered.

Signature Owner/Agent_____ Date_____