Date _____

Client Form

Owner _____ Phone #'s _____ _____

Address _____

City/State/Zip_____County_____

E-mail _____

Employer _____ Phone # _____

Spouse or Co-owner_____ Phone # _____

Address (if different than above) _____

City/State/Zip _____ County _____

Employer _____ Phone # _____
Other persons authorized to seek treatment for your pets (and phone #'s)
_____

How did you hear about us? _____

Pet name_____ Canine Feline Male Female Neutered Spayed

Breed_____ Age or Birth date_____

Last vaccinations (Date and kind) _____

Other illnesses or pertinent information_____

I certify that I am of legal age and have the authority to enter into this contract/ agreement with My Zoo Animal Hospital. I agree to pay My Zoo Animal Hospital reasonable and customary fees for the treatment of my pets. I understand that payment is by cash, MasterCard, Visa, or Discover and is due when service is rendered unless arrangements are made in advance. I understand that I am liable for any and all fees incurred by Dr. Leach and My Zoo Animal Hospital in collection procedures including all legal and court cost (including reasonable attorney fees). I also agree to pay interest and billing fees of 1.5% per month, which is 18% annually. (Minimum $1.37)
Signature(s)_____

Preferred method of payment Cash MasterCard Visa Discover American Express
Care Credit