

Ellington Center Animal Clinic PC

CLIENT REGISTRATION FORM

Name: _____ Spouse/Partner: _____ Date: _____

Street Address: _____ Town: _____ Zip: _____

E-mail: _____ Driver's License # _____

For I.D. when paying by check or credit card

Preferred Contact Number: (day) _____ (evening) _____
home cell work other home cell work other

How did you first hear of us? yellow pages sign / driving by newspaper
 recommended by: _____
 other: _____

Please list family pets:

Pet's Name: _____ Birth Date: _____ Species: cat dog other _____
Breed: _____ Sex: _____ Spayed/Neutered: YES NO
What percent of the time is your pet indoors? _____ outdoors? _____
Do you protect your pet from heartworm disease and intestinal parasites year-round? YES NO
Prior Medical Problems (if any) _____
Current Medications (if any) _____

Pet's Name: _____ Birth Date: _____ Species: cat dog other _____
Breed: _____ Sex: _____ Spayed/Neutered: YES NO
What percent of the time is your pet indoors? _____ outdoors? _____
Do you protect your pet from heartworm disease and intestinal parasites year-round? YES NO
Prior Medical Problems (if any) _____
Current Medications (if any) _____

Please list additional pets on another form

Preferred Method of Payment: cash check credit card/debit CareCredit (6 months interest free)

AUTHORIZATION

I hereby authorize Ellington Center Animal Clinic to treat my family pet(s). I assume responsibility for all charges incurred. I understand that payment is expected at the time of treatment and that a deposit may be required before hospitalization. The clinic accepts cash, checks, Visa, MasterCard, American Express, Discover Card and most debit cards. The clinic also accepts a 3-month, interest free payment plan available through CareCredit. I agree to pay a \$25 charge for checks returned for insufficient funds and for any appointments for which I fail to show or cancel with less than 24-hour notice.

In accordance with the Fair and Accurate Credit Transactions Act of 2003, the clinic considers the primary client to be the individual who signs this authorization to treat. Spouses and partners listed on this form have equal authority to make medical decisions and to accept treatment plans. I am financially responsible for payment, whether the services are approved by me or my spouse/partner.

If I or my spouse/partner cannot be reached and my pet is presented to the clinic by a pet sitter or kennel attendant,
I () do () do not authorize the clinic to treat my family pet(s). I assume responsibility for all charges incurred.

Signature of Owner or Agent: _____ Date: _____