

GALION VETERINARY HOSPITAL
Client Information Record

Name _____ Driver License # _____
(Financially Responsible Person) (Required)

Secondary Contact: _____ Driver License# _____
(Spouse, Family Member Significant Other) (Required)

Address _____ Email Address: _____

City _____ State _____ Zip Code _____

Phone Numbers:

Primary Contact:	Secondary Contact:
Home _____	Home _____
Mobile _____	Mobile _____
Work _____	Work _____

Owner(s) Place of Employment: _____

Secondary Contacts Place of Employment: _____

How Did You Hear About Our Clinic? _____

PLEASE READ: INITIAL & SIGN

Thank you for choosing Galion Veterinary Hospital. We would like to inform you of our financial policy before the doctor sees your pet today. This will give you a better understanding of what our expectations are concerning financial responsibility. We accept cash, credit card and checks. We require a Photo I.D. and will only accept a check with a Social Security number AND a Photo I.D. Please check the method (s) of payment you will be using:

PLEASE INITIAL YOU HAVE READ THE ABOVE: _____

METHOD(S) OF PAYMENT:

CASH _____	CREDIT CARD _____	CHECK _____	SS# _____
			SS# _____
			(Checks Only)

AUTHORIZATION:

I HEREBY AUTHORIZE THE VETERINARIAN TO EXAMINE, PRESCRIBE FOR, AND/OR TREAT MY PET. I ASSUME FINANCIAL RESPONSIBILITY FOR ALL CHARGES INCURRED IN THE CARE OF MY PET. I ALSO UNDERSTAND THAT THESE CHARGES WILL BE PAID AT TIME OF SERVICE AND THAT A DEPOSIT MAY BE REQUIRED FOR TREATMENT(S) OR SURGERY.

SIGNATURE OF OWNER: _____ DATE: _____

WHOM MAY WE SPEAK TO REGARDING YOUR PET (OTHER THAN YOU):

1) _____ 2) _____

CLINIC USE ONLY:

