Community Animal Hospital 2021

Name_____
_
First Last

Address_____
City_____ State_____ Zip Code_____
Cell #_____ Home #_____
Email _____
Employer Name_____ Work #_____

Spouse's Name_____ Cell #_____
Spouse's Employer Name_____
Spouse's Work #_____

PETS Name_____
Name_____ Species_____
Species_____ Breed_____
Breed_____ Male / Female Neuter / Spay Male / Female Neuter / Spay Birthday _____-_____-_____ Birthday _____-_____-_____ Color_____
Weight_____ Color_____ Weight_____

Initials

_____ I hereby authorize Community Animal Hospital to examine, prescribe for, treat, or perform surgery upon the above described pet(s). I also consent to the administration of such anesthetics as are necessary. _____ I agree to pay the fees for services rendered at the time the pet is discharged from the clinic or when service is otherwise terminated. In case of default of payment, I promise to pay any legal interest of 1.5% on the balance dues, together with any collection agency costs and reasonable fees.

Signature of Owner or Responsible Agent Date