

# McAfee Animal Hospital

651 Eastport Centre Dr.

Valparaiso, IN 46383

**"Where caring and community matter"**

## Client Information (please print):

Client Name \_\_\_\_\_ Spouse Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cel Phone/Name \_\_\_\_\_ 2<sup>nd</sup> Cel Phone/Name \_\_\_\_\_

DOB \_\_\_\_\_ Place of Employment/Phone \_\_\_\_\_

SSN \_\_\_\_\_ Email \_\_\_\_\_

Driver License # \_\_\_\_\_ Exp \_\_\_\_\_ State \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

**Payment is due in full at the time service is rendered.** This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including billing fees, reasonable attorney fees and costs of collection in event of default. **Any financial constraints need to be communicated prior to treatment.** I will be using the following method of payment :

Cash \_\_\_\_\_ Check \_\_\_\_\_ Credit Card \_\_\_\_\_ Care Credit \_\_\_\_\_

**Your Full Name** \_\_\_\_\_ **Date** \_\_\_\_\_

## Pet Information :

Name of pet \_\_\_\_\_ Species \_\_\_\_\_

Age/Date of Birth \_\_\_\_\_ Breed \_\_\_\_\_ Color \_\_\_\_\_

Sex: Male \_\_\_\_\_ Neutered Male \_\_\_\_\_ Female \_\_\_\_\_ Spayed Female \_\_\_\_\_