



WELCOME TO OUR CLINIC

We are glad to have the opportunity to care for your pet.
To ensure your pet gets the best care we can offer, please fill out this form completely.

Client Information:

Date: ____/____/____ County _____

Owner's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security No. ____/____/____ Birthdate: ____/____/____

Home Phone: (____) _____ Work Phone (____) _____

Email: _____

Knox Pet Clinic
658 West Main Street
Galesburg, IL 61401

Knox Pet Clinic
105 Public Square
Knoxville, IL 61448

Employer: _____

Emergency Contact Name: _____ Phone: (____) _____

Number of Pets (please specify type): _____

Pet Health History:

Pets Name: _____ Age: _____

Type: _____ Breed: _____ Color: _____

Sex: M F Neutered/Spayed: Y N Date: ____/____/____

Current medications your pet is taking: _____

Vaccination History:

Distemper Date: ____/____/____ Parvovirus Date: ____/____/____ Rabies Date: ____/____/____

Primary reason for visit: _____

Financial Policy

All past due accounts are subject of a finance charge of 1.5% per month or maximum rate allowed by law. The undersigned responsible party promises to pay for services in accordance with the above terms. If, at any time, for any reason, the undersigned is unable to pay for services when due, the undersigned agrees to pay and authorizes Knox Pet Clinic to bill their account finance charges as described above. In the event it becomes necessary for Knox Pet Clinic to incur collection cost or institute suit to collect any amount due under this agreement, the undersigned also agrees to pay collection fees and expenses, including reasonable attorneys' fees and court cost, plus all legal fees if incurred for collection and submits to jurisdiction and venue in Knox County, IL. I hereby certify that I have read and agree to the above terms.

Authorization:

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the care of the animal. I also understand that all professional fees are due at the time services are rendered.

Signature of responsible party _____ Date: ____/____/____

The information on this form is strictly confidential and is to be used only by this practice to provide care and treatment for you pet.