Fourmile Veterinary Clinic Medical Records

Please complete the following information for our medical records. Thank you for giving Fourmile Veterinary Clinic the opportunity to care for your pets.

Client Information:

First name________________ **Middle name**______________ **Last name**________________

Birthdate:____________ Cell Phone: ____________ Home Phone:____________

Home Address ________________________ Email: ____________
Street City State Zip

Mailing Address (if different from above) ________________________
Street /P.O. Box City State Zip

Place of Employment____________________ Work Phone:____________

Spouse's First name____________ **Middle name**__________ **Last name**____________

Spouse's Birthdate:____________ Email:____________ Spouse's Cell Phone:____________

Spouse's Place of Employment____________________ Work Phone:____________

Relative/Friend Contact ____________________ Phone home: ________ cell:________

Relative/Friend Contact ____________________ Phone home: ________ cell:________

How did you choose our clinic? ☐ I was referred by: ________________ ☐ Phone book ☐ Other:____________

Payment Policy: *(Please have your Driver's License available for ID & processing your payment.)*

Full payment is due at the time of the appointment. We do not charge. We accept Cash, Debit Cards, MasterCard, Visa, Discover, and Checks.
Returned checks are electronically debited from your account for the amount of check plus a returned check fee of $20.00.
FINANCE CHARGE is 1.5% per month (18% annually) interest accrues on unpaid balances 30 days past due, $5.00 monthly statement mailing fee. You are liable for all attorney fees and costs if collections proceedings are required.
I understand that I will be responsible for payment of all fees incurred in the collection of the unpaid balance.

If payment cannot be made, please notify the receptionist so we can reschedule the appointment at a more convenient time for you.

Authorization:

I hereby authorize the veterinarian to examine, prescribe for, and treat my pets. I assume responsibility for all charges incurred in the care of my animals. I also understand that these charges will be paid at the time of service and that a deposit may be required for treatment.

Signatures: ____________________________ Date____________

(For office use: Client information update year: ____, ____, ____, ____, ____, ____, ____, ____, ____, ____, ____)

To be completed by office staff:

DL full name____________________ DL full name____________________
DL address____________________ DL address____________________
DL state______ DL#____________ DL state______ DL# ____________
DOB____ HT:___ WT:___ HAIR:___ EYE:___ DOB____ HT:___ WT:___ HAIR:___ EYE:___