Troy & Wentzville Veterinary Clinic's LLC.

Thank you for giving us the opportunity to care for your pet. We are always happy to answer any questions you may have about your pet's health. To ensure the best possible care, please take the time to completely answer the following information. You must be 18 years of age to complete this form.

PLEASE PRINT CLEARLY

CLIENT/ OWNER INFORMATION

Last Name: _____ First Name:_____

Address: _____City: _____State:_____Zip:_____

County:_____

Home Phone:(____)_____Cell Phone:(_____)_____E-Mail :_____

May we use your email address to send you reminders? Yes ____ No____

Spouse/Co-owner(s):_____Spouse/Co-owner Phone:_____

Emergency Contact: _____ Phone Number: (____)_____

Employer: _____ Work Phone Number: (_____)_____

** I authorize the release of my pets' medical records, which may contain person information (i.e. address and phone numbers) to any outside entity (e.g. State/Couty Official, licensed veterinarian, groomer, or boarding facility) upon request. This authorization is valid until revoked in writing by person listed above.

AGREE (initial here)_____ **DISAGREE (initial here)**_____

Pet Information	Pet # 1	Pet # 2	Pet # 3
Name			
Species			
Breed			
Color			
Birthdate /Age			
Gender	Male / Female	Male / Female	Male / Female
Spayed / Neutered	Yes / No	Yes / No	Yes / No
Previous Veterinarian			
Date of last Vaccines			
Current Medications			
History of seizures			
Any known allergies			

Please provide previous medical records for extensive medical history and medications.

Authorization

I hereby authorize the veterinarian to examine, prescribe medications for and/or treat my pet(s). I understand that trained personnel will not attend to boarded or hospitalized animals beyond regular business hours.

Signature: _____ **Todays Date:**_____

Please turn over and complete back of form →

Client #

Troy & Wentzville Veterinary Clinics, LLC.

Financial Policy

All professional fees are due at the time the services are rendered.

A deposit may be required for extensive hospitalization or emergency procedures. We accept Cash, Visa, MasterCard, Discover, American Express, CareCredit and personal checks with proper forms of identification. We do not accept counter or post-dated checks and will not hold checks for any period of time. There will be a $25.00 administration fee for all returned checks.

We require a valid Driver's License and Social Security number to be on file prior to accepting checks, credit cards, or debit cards.

Social Security #:_____

Driver's License #:_____ State:_____ D.O.B.:_____

For convenience we can take a photo copy of your Drivers License or Legal photo ID Card

We understand that situations may arise that a client will need to make payments to our office. Payment arrangements must be approved by our office prior to any procedure being performed. Monthly interest of 1.5% and a $3.00 monthly billing charges will be added to all accounts with a balance past 45 days. All accounts more than 90 days past due, will be assigned to a collection agency, a collection fee of up to 25%of the balance owed on your account will be added to your account. Once your account is forwarded to a collection agency, you will be responsible for that collection fee, in addition to the balance owed on your account at that time. A 3% fee will be added to all credit card transactions, based off of the invoice amount. This does not apply to Debit transactions, Carecredit, checks or cash payments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read and understand the above Financial Policy and Agree to the terms.

Signature of Responsible Party:_____ Date:_____