ANIMAL EYE CARE CENTER

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REGISTRATION DOCUMENT

** CLIENT INFORMATION **

First Name:	Last Name:
Driver's License No./Social Security No. (for check pymt)	Home Phone: ( ) Cell Phone: ( )
Home Address: City:	State: Zip Code:
Place of Employment:	Phone: ( )
Spouse / Co-owner:	
Spouse / Co-owner's Employment:	Phone: ( )

** PET'S INFORMATION **

Pet's Name:	Species: Dog Cat Bird Other:
Sex: Male / Female	Neutered / Spayed? Yes No
Breed of Animal:	Date of Birth:
Is your pet allergic to any medication? If so, what?	**Can your pet be aggressive?** Yes No Sometimes

** VETERINARY INFORMATION **

Name of your veterinarian:
Hospital name and phone number:
How did you hear about us?

I ASSUME FULL FINANCIAL RESPONSIBILITY FOR ALL CHARGES INCURRED TO THIS PATIENT. PAYMENT FOR SERVICES IS DUE **IN ITS ENTIRETY AT THE TIME THAT SERVICES ARE PROVIDED**. IF A CHECK IS RETURNED, THE OWNER AGREES TO PAY A $25.00 PROCESSING FEE. IF FOR ANY REASON THE CHARGES ARE NOT PAID IN FULL AT THE TIME OF THE PET'S RELEASE, I WILL BE RESPONSIBLE NOT ONLY FOR THE BALANCE DUE, BUT FOR A $10.00 MONTHLY BILLING FEE, AS WELL AS FOR ANY COLLECTION AND/OR REASONABLE ATTORNEY FEES THAT ARE INCURRED IN THE ATTEMPT TO COLLECT THIS DEBT.

****IF YOU DO NOT SHOW AND DO NOT CALL TO CANCEL/RESCHEDULE AN APPOINTMENT, YOU WILL BE REQUIRED TO PRE-PAY FOR THE NEXT EXAM. REFUNDABLE ONLY IF EXAM IS CANCELLED/RESCHEDULED AT LEAST 24 HOURS BEFORE APPOINTMENT TIME.**

Types of payment accepted - Visa Mastercard Discover Check Cash

Signature:	Date: