PAWS AND CLAWS VETERINARY HOSPITAL

1924 West 11th Street, Tracy, CA 95376

OWNER'S NAME (LAST) _____/ (FIRST)

_____SPOUSE_____

ADDRESS_____APT/LOT#_____

_____

CITY_____ STATE_____ ZIP CODE_____

HOME PHONE #_____**CELL PHONE #**_____WORK #_____

We txt people so put you cell phone carrier here (T-mobile, Sprint, AT&T, etc)_____

BIRTH DATE _____LAST 4 of SS#_____

DRIVER'S LIC. #_____ STATE ISSUED/EXP. DATE_____

E-MAIL_____FORMER VET_____

REASON FOR LEAVING (FORMER VET)

_____

HOW DID YOU CHOOSE OUR HOSPITAL?( ) YELP, ( ) ONLINE, ( ) DROVE BY, ( ) REFERRAL

WHO MAY WE THANK FOR REFERING YOU

_____

*********PAYMENT IS DUE AT THE TIME OF SERVICE, NO CHECKS**********

NAME _____	NAME _____	NAME _____
SPECIES DOG CAT	SPECIES DOG CAT	SPECIES DOG CAT
BREED _____	BREED _____	BREED _____
COLOR_____	COLOR_____	COLOR_____
SEX _____	SEX _____	SEX _____
SPAYED/NEUTERED_____	SPAYED/NEUTERED_____	SPAYED/NEUTERED_____
DATE OF BIRTH _____	DATE OF BIRTH _____	DATE OF BIRTH _____
DATES VACCINATED_____	DATES VACCINATED_____	DATES VACCINATED_____

Financial Agreement and Authorization: I authorize treatment of the above named pet (s) and agree, irrevocable, that in consideration of the services to be rendered that I herby obligate myself to pay the account in accordance with the regular rates of the provider. As required by law you are hereby notified that a negative report reflecting on your credit reporting agency if you fail to fulfill the terms of your credit obligation. Should the account be referred to an attorney or collection agency for collection, the undersigned agrees to pay actual attorney's fees and plus 30% service charge. I authorize my employer to release employment information to the provider or the

provider's agents. I acknowledge that this facility has audio and video monitoring and all phone calls can be recorded. There may be times when no personnel are on the premises. I affirm that I am 18 years of age or older and legally authorize to approve treatment/services.

Full payment required at time of service and final bill is upon release of the patient.
NO BILLING.

Signature: _____ Date: _____