Glasgow Veterinary Medical Center

629 Grandview Ave
Glasgow, KY 42141

NEW CLIENT INFORMATION

DATE:_____

Owner's Name _____

Spouse / Other _____ Employer _____

Social Security Number_____ Driver's License _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Home phone_____ Work Phone_____ Cell _____

E-Mail_____ Emergency Contact _____

Pet Information

Pet's Name _____ Species _____ Breed _____

Color _____ Date of Birth _____ Sex: ___M ___F

Neutered/Spayed: ___ Yes ___ No

Additional Pets:

Name _____ Species _____ Breed _____

Name _____ Species _____ Breed _____

Name of previous Veterinarian: _____

Is your pet on any medication? ___ Yes ___ No. If so, what kind: _____

Does your pet have any allergies? ___ Yes ___ No If so, what to: _____

ALL FEES ARE DUE AND PAYABLE UPON COMPLETION OF SERVICES

Method of Payment ___ Cash ___ Check ___ Credit Card

I understand every effort will be made to achieve a successful outcome and to provide for all possible safety in hospital care and handling. I hereby authorize this facility to receive, prescribe for, treat or perform surgery upon the pet(s) listed above. Furthermore, I agree to pay fees for all services rendered at the time the pet is discharged from the hospital or the service is otherwise terminated. I agree to pay for the reasonable costs of collection, attorney fees and court cost in the event that collection efforts become necessary. I agree that the venue of this action will be in the county where the hospital is located. I understand that veterinary service provided after hours as necessary in the judgment of the veterinarian in charge. Continuous presence of qualified personnel may not be provided.

Signature _____ Date _____