ANIMAL MEDICAL CENTER
321 WEST COLUMBIAN BLVD. SOUTH
LITCHFIELD, ILLINOIS 62056
217-324-3311

WELCOME TO OUR HOSPITAL. SO THAT WE MAY BECOME BETTER ACQUAINTED, PLEASE COMPLETE THE FOLLOWING INFORMATION.

DATE_____

OWNER'S NAME_____CELL #_____

SPOUSE'S NAME_____CELL #_____

ADDRESS_____COUNTY_____

CITY & STATE_____ZIP CODE_____

HOME PHONE (_____)_____**EMAIL ADDRESS** _____

OWNER'S EMPLOYER_____OWNER'S WORK #(_____)_____

SPOUSE'S EMPLOYER_____SPOUSE'S WORK #(_____)_____

OWNER'S S.S. #_____DRIVER'S LICENSE #_____

SPOUSE'S S.S. #_____DRIVER'S LICENSE #_____

HOW DID YOU CHOOSE OUR CLINIC? (PLEASE CHECK)

- ☐ FRIEND/RELATIVE (WHO?)_____
- ☐ HERE PREVIOUSLY
- ☐ CLINIC SIGN
- ☐ YELLOW PAGES

ALL FEES ARE DUE AND PAYABLE UPON COMPLETION OF SERVICES

PLEASE CIRCLE ANY FORM OF PAYMENT THAT YOU MAY WANT TO USE NOW OR IN THE FUTURE:

CASH CHECK VISA MASTERCARD DISCOVER

BANK_____CITY_____

PAYMENT BY CASH, CHECK, OR CREDIT CARD IS EXPECTED WHEN TREATMENT IS PERFORMED OR ANIMAL IS DISCHARGED. IN THE CASE OF EMERGENCY HOSPITALIZATION, A DEPOSIT ARRANGEMENT MUST BE MADE WITH THE CLINIC. ON YOUR REQUEST WE WILL PROVIDE YOU WITH A WRITTEN ESTIMATE OF FEES BEFORE CARE IS PROVIDED. A $2 BILLING AND A 1.50% FINANCE CHARGE WILL BE ADDED TO ANY UNPAID BALANCE AFTER 30 DAYS.

I UNDERSTAND THE CREDIT POLICY OF THE ANIMAL MEDICAL CENTER AND AGREE TO THE TERMS AS STATED ABOVE.

CLIENT SIGNATURE_____DATE_____