Welcome!

817-478-9238 | 5820 West I-20, Arlington, TX 76017 | i20animal.com

I-20 Animal Medical Center

Client Information

Primary Name

First: _____ Last: _____

Secondary Name

First: _____ Last: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Email: (used for reminders and updates) _____

Phone Contact

Primary: _____-_____ Primary Alternative: _____-_____

Secondary: _____-_____ Secondary Alternative: _____-_____

Driver's License #: _____ State Issued: _____ DOB _____

How did you hear about us? Referred by: _____

Pet Information

Pet's Name: _____ Sex: Male _____ Female _____

Spayed/Neutered: Yes _____ No _____ DOB/Approximate Age: _____

Dog _____ Cat _____ Other (Specify) _____ Breed: _____ Color: _____

Markings: _____

If you are here for an emergency and would like I-20 Animal Medical Center to fax your pet's medical records to another veterinarian, please complete the following:

Clinic Name: _____ Doctor: _____

City: _____ State: _____

Reason for Visit: _____

I hereby authorize the veterinarian to examine, prescribe for, or treat the above patient. I assume responsibility for all charges incurred in the care of the animal. I also understand that all professional fees are due at the time services are rendered. In the event of default, we will charge 1.5% interest monthly & if it becomes necessary to place this account in the hands of a third party for collection, the client agrees to pay all costs of collection, including reasonable attorney's fees & court costs.

Signature: _____ **Date:** _____ /_____ /_____

Office Use: CID# _____ Time: _____ Initials: _____