Rockwall County Veterinary Clinic

Essential Client Information

Client (last, first name) _____Spouse/Other_____

Address_____

City _____State_____Zip_____

Home Phone_____

Mrs. Cell_____ Mr. Cell _____

Drivers License Number _____State_____ Client DOB ___/____/_____

Employer _____ Work Phone _____

Spouse / Other Employer _____ Work Phone _____

How did you find out about us?_____ Name of referral _____

Email Address _____

We will gladly prepare a written estimate if you desire (please ask receptionist or doctor). This will be important to you since ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. If hospitalized a deposit may be required. We accept cash, check, Mastercard, Visa, Discover and Care Credit. There will be a $35.00 service charge for any returned check or should we need to send you to collections.

To prevent the spread of infectious diseases, all hospitalized/boarding/grooming patients must be current on all vaccines and free from internal and external parasites. The signature below authorizes this level of preventative care and the appropriate charges will be assessed in the discharge invoice.

Signature of responsible agent for pet(s) _____Date _____

**Essential Pet Information**

**Name of clinic(s) who have previously seen your pet(s):**

**Clinic Name _____Phone number_____**

| Cat | Dog | Pet's Name | DOB | Sex | Neutered/Spayed | Breed/Description | Color | Microchip Y/N |
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