RIPPOWAM ANIMAL HOSPITAL

DATE: _____

OWNER INFORMATION

PLEASE PRINT AND COMPLETE ALL INFORMATION

PET OWNER'S NAME: _____

HOME PHONE: _____ CEL PHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMERGENCY PHONE: _____ E-MAIL ADDRESS: _____

ARE THERE ANY OTHER OWNERS? ☐ **YES** ☐ **NO**

CO-OWNER'S NAME: _____ PHONE: _____

ANY OTHER PEOPLE AUTHORIZED TO MAKE TREATMENT DECISIONS? _____

RELATIONSHIP: _____ PHONE: _____

ANIMAL INFORMATION

Dog/Cat	Name	Breed	Color	Spay Neuter?	Sex	DOB

PAYMENT INFORMATION

Professional fees are to be paid at the time services are rendered. Client will be responsible for a 1.5% monthly finance charge on accounts over 30 days and any collection fees on accounts over 90 days.

FORM OF PAYMENT PLANNED: ☐ **CASH** ☐ **CREDIT CARD** ☐ **CHECK** ***(Returned Check Fee $35.00)***

SIGNATURE OF OWNER OR AGENT: _____

If someone referred you, please let us know so that we may thank them: _____

Payment in FULL is expected at the time of service.

888 High Ridge Road, Stamford CT 06905 203-329-8811