Animal Clinic of Rapid City
New Client Information

PLEASE FILL ENTIRE FORM OUT- IF UNKNOWN OR NOT AVAILABLE WRITE **NA**

Contact Information

Date_____

Last Name_____ First Name_____

Address_____Zip_____

Apt. #_____ Lot # _____ Home phone #_____

City _____State_____ Work # _____ Cell # _____

County_____ Email Address:_____

SSN _____-_____-_____ **OR** Drivers License _____

Date of Birth:_____ (mm/dd/yyyy)

Employer _____ Spouse/Other _____

If a spouse or other authorized person is listed on this form, you are authorizing our clinic to release all information to this particular individual in regards to your account or pet(s)

Personal Information:

In case of EMERGENCY, call_____ Phone # _____

We will contact this person only in the case of an emergency and no information will be released unless authorized.

How did you become aware of the clinic?

Yellow Pages_____ **Web Site**_____ **Newspaper**_____ **Radio**_____

Other (please specify) _____ **Individual** _____

ALL FEES ARE DUE AND PAYABLE UPON COMPLETION OF SERVICES

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 herby authorize this hospital 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 services are otherwise terminated. I agree to pay for the reasonable costs of collection, attorney fees, and court costs 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 is provided during nighttime hours as necessary in the judgment of the veterinarian in charge. Continuous presence of qualified personnel may not be provided.

Signature _____ Date _____

Hospital Employee _____

Method of payment: Cash_____ Check_____ Credit Card_____ Care Credit _____