CHESDIN ANIMAL HOSPITAL

We look forward to serving you and your pet. Please complete the following information for our records.

Name____________________________ **Soc. Sec. #** ____________

Address_____________________________________

City/State/Zip_________________________________

Home Phone_______________________ **Cell Phone**____________

Work Place________________________ **Work Phone**___________

Spouse's Name_____________________ **Work Phone**___________

	Pet #1	Pet #2	Pet # 3
Pet's Name			
Species (Canine, feline ect.)			
Sex			
Breed			
Age/Birthday			
Color			
Allergies			
Any Problems			

BILLING POLICY: Payment is due at the time of service. It is our policy not to extend credit for routine office visits and elective surgeries. We accept cash, check, Visa, Master Card, Discover and American Express. There is a $30.00 fee for all returned checks.

I HAVE READ AND AGREE TO THE ABOVE CONDITIONS.

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Signature **Date**