**THE DALLES VETERINARY HOSPITAL**

**(541) 296-9191**

408 West Third Street ● The Dalles, OR 97058

**CLIENT INFORMATION**

**==============================================================================**

 Date: Client ID#:

Welcome to **The Dalles Veterinary Hospital.** Thank you for giving us the opportunity to care for your pet(s).

Please complete the following information for our records.

Owner’s Last Name Owner’s First Name(s)

Other legal Owner

Mailing Address (Street/Po Box)

 (City) (State) (Zip)

Home Phone ( ) Cell Phone ( )

Work Phone ( ) Other legal Owner’s Phone ( )

E-mail address

Employer Occupation

May we call you at work? □ Yes □ No **May we use pictures of your pet on social media? □ Yes □ No**

Other authorized agent(s) who is/are authorized by owner of animal to make medical and financial decisions:

Name(s) of Pet(s)

**PAYMENT OF FEES IS REQUIRED IN FULL AT THE TIME SERVICE IS RENDERED.**

*On your request we will provide you with a written estimate of fees. A deposit prior to treatment may be required. There is a finance charge applied to all accounts unpaid after 30 days at a rate of 1.5% per month with a minimum charge of $1.50. There is a $35.00 returned check fee.*

Please indicate your choice of payment: □ CASH □ CHECK □ VISA/MC/DISCOVER

* **I am at least 18 years old and the owner or authorized agent for the above animals.**
* **I understand that I am responsible for payment.**

Owner’s Signature