THE DALLES VETERINARY HOSPITAL

(541) 296-9191

408 West Third Street ● The Dalles, OR 97058

CLIENT INFORMATION

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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 _____