

RIVERVIEW ANIMAL CLINIC---CLIENT INFORMATION

DATE: _____

Phone # _____

Name: _____ SS# _____ - _____ - _____

Method of Payment: *Cash* () *Visa/MC/Discover* () *Check* ()

Driver's License # _____ (We **MUST** have this to accept your checks.)

Spouse: _____ SS# _____ - _____ - _____

Address: _____ City: _____ Zip: _____

Employer: _____ Phone # _____

Spouse Employer: _____ Phone # _____

Emergency Contact: _____ Phone # _____

Who may we thank for your referral _____

Please provide us with your pets' information:

Dog/cat	M/F	Birth date	Color	Breed	Name
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

AUTHORIZATION

I hereby authorize the Veterinarians at Riverview Animal Clinic to examine, prescribe for, or treat the above described pet(s). I assume responsibility for all charges incurred in the care of the above animals. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment.

Signature of responsible party _____ Date _____
