

**COUNTRYSIDE VETERINARY CLINIC  
OWNER/PATIENT REGISTRATION**

Owner's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Co-Owner's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Spouse's Phone: \_\_\_\_\_ Spouse's Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Pet's Name: \_\_\_\_\_ Pet's Age/DOB: \_\_\_\_\_

Circle One: Male / Female      Cat / Dog / Other \_\_\_\_\_

Is your pet Spayed or Neutered?      Yes      No

Breed: \_\_\_\_\_ Color: \_\_\_\_\_

Previous Doctor or Clinic Name: \_\_\_\_\_

May we request your records?      Yes      No

How did you learn of our clinic? \_\_\_\_\_

If personal recommendation, name of person: \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_

Driver's License Number (for checks): \_\_\_\_\_

Reason for visit: \_\_\_\_\_

I understand that I am financially responsible for all charges arising from the care and treatment for the above-named patient and any other patients for whom I request care or treatment in the future. I understand that all fees are due at the time the patient is released. I understand that I may request a written estimate of fees for any case where hospital treatment, emergency care, surgery or hospitalization will be provided, and a deposit may be required prior to treatment depending on the amount of the estimate. We require a Social Security Number if a check is written. In the event any check given in payment on the account is returned by my bank unpaid for any reason, a \$35.00 charge will be added to the account balance each time such a check is returned. I understand that payment in full is due at the time services are rendered; however, I agree to pay a FINANCE CHARGE of 1.5% per month on balances over thirty (30) days past due, which is an annual percentage of 18%. I further agree to pay a Statement Handling fee of \$3.00 for each invoice, which may be generated monthly. If this account is referred to an attorney for collection, I agree to pay all costs of collection, including, but not limited to attorney's fees in the amount of thirty-three and one-third percent (33 1/3%) of the balance owed or actual attorney's fees, whichever is greater.

Owner's/Co-Owner's Signature: \_\_\_\_\_