Pet Medical Center
57 East 3rd St.
Winona, MN 55987

New Client ____ New Pet____
Info Update_____
Entered by:_____

Client Registration

***Please fill out reverse side**

Thank you for choosing our animal clinic. We pride ourselves in offering high quality medical care and emphasize preventive medicine. We look forward to serving you and caring for your pet's needs for many years to come. Please complete this form so we can accurately enter this information into our files. To open an account with us, you must be at least age 18 and provide a photo ID, such as driver's license or state ID.

Owner's Name:_____ Home Phone #: (____) _____

Home Address: _____ Cell Phone #: (____) _____
(Street address)

_____ Email Address: _____
(Mailing address) (For free internet access to your account & pet reminders)

_____
(City) (State) (Zip) **Spouse's Name:** _____

Employer: _____ **Spouse Employer:** _____
(Required)

Address: _____ Address: _____
(Street) (Street)

_____ _____
(City, State, Zip) (City, State, Zip)

Work Phone #: (_____) _____ Work Phone #: (_____) _____

The following information is required for your account and is strictly CONFIDENTIAL:
DATE OF BIRTH: _____/_____/_____ (Required)
Driver's License #: _____ State _____

How do you plan to pay for today's services? Circle one: **CASH** **CREDIT CARD**
Payment is due in full at the time of service. *We accept cash and credit cards;* ***Visa, Master Card, Discover, American Express*** *and we offer* ***Care Credit*** *if you need a payment plan.*

How did you hear about our clinic? Internet Search: _____ Phone Book: _____ Drove By: _____
Radio: _____ Newspaper: _____ Other: _____
Referral: _____ Whom may we thank for referring you? _____

Authority to use Images of your pet(s): I, the undersigned, do hereby certify that I am the owner (duly authorized agent for the owner) of the pet(s) described above, and that I do hereby give, Pet Medical Center, full and complete authority to use images of my pet(s) in promotional materials, news releases and other published formats. ☐ **Yes** ☐ **No** _____ Initials

Do you authorize email communication? ☐ **Yes** ☐ **No** _____ Initials

Do you authorize text communication? ☐ **Yes** ☐ **No** _____ Initials
* Standard text rates may apply.

We pledge to do our very best to care for your pet's health needs. In return we ask you to accept the responsibility for charges incurred in the treatment of your pet and accept that **payment is due when services are rendered.** Please feel free to ask for an **Estimate** prior to providing services. If at any time you are not satisfied with our services, please let us know. We will be happy to answer your questions.

Agreement Terms: Balances due over 30 days will be charged a 1.5%/monthly interest charge (18% APR). Checks returned for non-sufficient funds will be charged $30 or 10% returned check fee (whichever is higher) and may be debited from your bank account electronically. Additional collection fees will be charged if your past-due account is sent to Collections or Small Claims Ct.

Client Agreement & Signature: _____ Date: _____

PET INFORMATION

Pet Name_____Species_____Breed_____

Color_____Date of Birth/Age_____Sex_____
Spayed/Neutered

Medical Conditions/Concerns _____

Vaccines & Dates Given _____

Clinic/Hospital Name _____

Pet Name_____Species_____Breed_____

Color_____Date of Birth/Age_____Sex_____
Spayed/Neutered

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