LEXINGTON PET CLINIC

Date: **Account #**

CLIENT INFORMATION

Owner: _____ Primary Phone #: _____
(Last) (First)

Address: _____ Cell Phone #: _____
(Apt/Unit #)

Address: _____ E-Mail: _____
(City) (State) (Zip)

In Case of Emergency:

Significant Other: _____ Phone: # _____

Other Contact: _____ Phone # : _____ Relationship: _____

REFERRAL INFORMATION

Thank you for coming to Lexington Pet Clinic. Please tell us how you found us by checking any of the following boxes that apply:

( ) A Personal Recommendation * ( ) Driving by/ Location ( ) Other _____
( ) Online Search/Website ( ) Humane Society/ Rescue Group _____

* If Personal Recommendation, whom may we thank for referring you?

Name: _____ Phone #: _____

Address: _____
(Street) (City) (State) (Zip)

SOCIAL MEDIA STATEMENT

Lexington Pet Clinic may ask to use photographs of your pet on our Website, Instagram or Facebook Page.

ANIMAL INFORMATION

Pet's Name: _____ Date of Birth: _____ Age: _____

Breed: _____ Color/Markings: _____

Species: _____ Dog Cat Sex: _____ Spayed / Neutered

Microchip #_____ Weight: _____

PAYMENT IS REQUIRED AT TIME OF SERVICE. FORM OF PAYMENT PREFERRED:

Cash **Visa** **MasterCard** **Discover**

I understand that payment is due for services when rendered. I also understand that all unpaid balances are subject to monthly interest and service fees as well as a fee of 45% of the balance if turned over to collections.

Signature: _____ Date: _____

OFFICE USE ONLY
Entered by: _____ Reviewed by: _____ Date: _____