



Primary Account Holder:

First name: _____ MI: _____ Last name: _____

Address: _____ City: _____

State: _____ ZIP: _____ Email: _____

Home phone: (____) _____ Cell phone: (____) _____

Preferred Method of Communication: Text Messaging Phone Call

Secondary Account Holder (This individual will have full authority to make decisions on treatments and can request pet's records) Relationship: _____

First name: _____ MI: _____ Last name: _____

Address: _____ City: _____

State: _____ ZIP: _____ Email: _____

Home phone: (____) _____ Cell phone: (____) _____

How did you hear about us? Newspaper/Magazine _____ Hospital sign Social media
Radio Personal referral Whom can we thank? _____ Other: _____

Pet Information

Name: _____ Age/Birthday: _____ Cat Dog Other _____ Breed _____

Color _____ Male Female Spayed or Neutered? Yes No Allergies? Yes No

Name: _____ Age/Birthday: _____ Cat Dog Other _____ Breed _____

Color _____ Male Female Spayed or Neutered? Yes No Allergies? Yes No

Name: _____ Age/Birthday: _____ Cat Dog Other _____ Breed _____

Color _____ Male Female Spayed or Neutered? Yes No Allergies? Yes No

_____ Please initials here if you will allow Cordova Animal Medical Center to use your pet's photo for our promotional purposes (website and social media).

- If you are not able to keep an appointment, please notify our office 24 hours in advance to cancel or to reschedule your appointment. This will enable us to help you with another appointment and to fill your slot with another patient in need.
- If you are Ten minutes (or more) late, you have forfeited the appointment time and are subject to be rescheduled. If you do not come to your scheduled appointment and/or give us less than the required notice time, two times, you will be required to prepay for all upcoming visits.

Payment is required at the time of service. For your convenience, we accept Mastercard, Visa, American Express, cash, or check (with a valid driver's license). Care Credit and Scratch Pay are great to have for emergencies with low to no interest fees. A deposit may be required for surgical procedures or hospitalization of your pet. Returned checks are subject to a \$35.00 fee. By signing this document, you agree that you are responsible for payment of all services rendered and that if payment becomes past due, it is subject to an interest rate of 18%.

Signature _____

Date _____