

PET MEDICAL CENTER *of Duncanville*



WELCOME TO PET MEDICAL CENTER OF DUNCANVILLE

ABOUT YOU: (PLEASE PRINT)

Date _____
Name _____
Address _____
City _____ State _____ Zip Code _____
Texas Drivers License Number: _____ Date of Birth _____
Sex: M F Referred By _____
Employer _____ Occupation _____
Home Phone Number _____ EMAIL _____
Work Phone Number _____ CELL _____
Spouse Name _____
Work Phone Number _____

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ABOUT YOUR PET:

Pet's Name _____ Date of Birth _____
Species: Dog ___ Cat ___ Rodent ___ Bird _____ (Write In)
Sex: M F Neutered/Spayed: Yes No Color _____ Breed _____

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WE WILL GLADLY PREPARE A WRITTEN ESTIMATE IF YOU DESIRE (PLEASE ASK OUR DOCTOR OR RECEPTIONIST).
ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. IN CASE OF EXTENSIVE MEDICAL
OR SURGICAL PROCEDURES WHERE FULL PAYMENT MAY BE DIFFICULT AT DISCHARGE, WE ACCEPT MAJOR
CREDIT CARDS OR CAN ESTABLISH A PAYMENT ARRANGEMENT IF APPROVED IN ADVANCE OF THE TREATMENT.
THERE WILL BE A SERVICE CHARGE FOR ANY CHECK RETURNED UNPAID.

TO PREVENT THE SPREAD OF INFECTIOUS DISEASES, ALL HOSPITALIZED PATIENTS MUST BE CURRENT ON ALL
VACCINES AND FREE FROM INTERNAL AND EXTERNAL PARASITES. THE SIGNATURE BELOW AUTHORIZES THIS
LEVEL OF PREVENTATIVE CARE AND THE APPROPRIATE CHARGES WILL BE ASSESSED IN THE DISCHARGE
INVOICE.

SIGNATURE OF CLIENT RESPONSIBLE FOR PET(S) _____