Canine Center

34740 N. Hwy 45, Lake Villa, IL 60046
Phone: 847-986-3644 Fax: 847-986-3588 www.caninecentervet.com

PATIENT INFORMATION

Call Name:_____ Sex: Male / Female Neutered Y / N

Breed:_____ Color:_____

Date of Birth:_____ Age: _____

Does your dog have any known medical problems?	Y / N	
Is your dog on any prescription medications?	Y / N	
Does your dog take any nutritional supplements / vitamins ?	Y / N	
Is your dog on heartworm preventative?	Y / N	Year Round / Seasonal
Is your dog on a tick preventative?	Y / N	Year Round / Seasonal
Does your dog have a microchip?	Y / N	

OWNER INFORMATION

Name (First & Last):_____ Drivers License #:_____

Address:_____

City:_____ State: _____ Zip:_____

Phone (Primary): _____ P(Secondary):_____

Alternative Contact Person:_____ Alteranative's Phone:_____

E-mail:_____ Employer:_____

MEDICAL AUTHORIZATION / FINANCIAL INFORMATION

I hereby authorize the doctors and assistants to administer treatment as is considered to be therapeutically and/or diagnostically necessary. I authorized medical treatment as well as possible alternative modes of treatment that are explained to me by the medical staff. I further authorize surgical procedures of an emergency nature if deemed necessary. I assume financial responsibility for all charges incurred to my pet. I further understand that if I fail to pay the entire amount I will be responsible for any and all attorney and collections costs incurred for the purpose of collection. A monthly administrate fee of 2% will be added to any unpaid balances over 30 days. A $35 fee will be imposed for any returned checks. I hereby authorize Canine Center or their agent to obtain credit reports on me at anytime sums remain due on my account. I hereby certify that I have read and full understand the above authorization. Payment is accepted in the form of cash, personal checks, Visa, and MasterCard. Accepted payment options for the first visit are cash, Visa, or MasterCard.

Signature:_____ Date:_____