PLANTATION CENTRE ANIMAL HOSPITAL

6411 PEAKE RD MACON, GA. 31210

(478) 474-3616 (478) 477-7126 Fax

Jeff Davis DVM Jill Lancaster DVM Cindy Brown DVM Shannon Elliott DVM Hays Fyke DVM

Owner Information: **Date: _____**

Name: _____ SSN: _____
Last First MI

Address: _____

City: _____ State: _____ Zip: _____

Home # (__) _____ Work# (__) _____ Cell# (__) _____

Employer:_____Email_____

Co-owner Name: _____ Co-owner phone number_____

Pet Information:

Pet Name: _____ Species: Feline Canine Other: _____

Breed: _____ Date of Birth/Age: _____

Color: _____ Sex: Male or Female / Neutered or Spayed

Previous Veterinarians and Phone Numbers: _____

Vaccination History: (List Dates)

Canine: Rabies: _____ Distemper/ Parvo:_____ Bordetella:_____ Heartworm Test:_____

Feline: Rabies: _____ Distemper (Fvrccp): _____ Leukemia: _____ FeLV/ FIV Test:_____

Please list any **Insurance** and M**edications** your pet is currently on:

_____

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Please list any **Insurance** and M**edications** your pet is currently on:

_____

We accept all major credit cards, Debit Cards, Checks with proper ID, CareCredit, and Cash.

*Payment is due when services are rendered or when patient is released from the hospital. We **do not** offer billing.*

Patients requiring hospitalization will require a deposit when admitted.

Any balance not paid in full or returned checks is liable to service charges, collection and/or legal fees.

I understand the above hospital policy and accept responsibility for all charges in caring for my pet.

Signature:_____Date:_____