

BURKE VETERINARY CLINIC NEW CLIENT INFORMATION				
TODAY'S DATE: (mm/dd/yyyy)			Office use only:	
LAST NAME:		FIRST NAME:		MIDDLE INITIAL:
Circle one: Mr. Mrs. Ms. Dr. Rank:				
Street address:				
City:		State:		Zip:
Mailing address (if different from above):				
City		State:		Zip:
Social Security Number:				
(This is required for us to accept checks. Without a SSN, you may pay by cash or approved credit card only.)				
Home phone:		Work phone:		Cell phone:
Other household members to be listed on this account:				
Last Name:		First Name:		Middle initial:
Circle one: Mr. Mrs. Ms. Dr. Rank;				
Home phone:		Work phone:		Cell phone:
If you were recommended by one of our clients, please give us their information so we may thank them:				
Name:			Phone:	
Pet's names:				
PAYMENT METHOD				
All services must be paid in full at the time of patient discharge. We accept cash, check, Visa, MasterCard, or Discover. WE REGRET THAT WE CANNOT BILL. There is a \$30.00 service charge for all returned checks. Any unpaid balance will be turned over to a collection agency, and you will be responsible for all costs of collection (50% of your outstanding balance).				
Signature of person responsible for payment:				
PET HISTORY				
Name:	Approx. birth date:	Species: Dog Cat Ferret Other_____	Breed:	Color/Markings:
Male Female Neutered Spayed		Distemper vaccination date:	Rabies: 1 yr 3yr Date:	Kennel cough vacc.:
Important medical conditions:				
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