Bay City Veterinary Clinic & Equine Hospital Emergency Service Agreement

Your Name:		Spouse		
Last	First		Last	First
Address:				
Street		City	State	Zip
Home Ph#	Cell#		Wk#	
Employer(yours):		Spouse:_		
Driver's License#		E-mail address:		
If a new client, how did yYellow PagesPersonal Recomme Pet/Patients information: (Hospital Signal Signal Hospital Signal Hospital Signal Hospital Signal Hospital Hospital Hospital Signal Hospital Hospital Signal Hospital Hospital Signal Hospital Ho	gn	Newspaper	Other
Name:	(If not a current)	Color:		
Species:		Prior Surge	ry/Illness:	
Breed:		Birthday/Ag	ge	
Sex:	Allergies/On	Meds?:		
Fees: All fees are due use Methods of payment: Cash, Ch Payment in full is required have been made with our be Accounts older than 90 day Client agrees to pay any arclients' account. If hospitalization/over nighting cash, check or credit card.	leck and Major Credit when the patient lead ousiness office, prior ys will receive no fur and all reasonable attor	t Cards ves the hospital to treatment. ther services un rney's cost and f	til paid in full fees, if any incur	red to collection of
Signature			Date	
Signature	Credit Ca	ard Use		
	Credit Card #			
Evn Date: Cre	edit Card Auth Si	anaturo		