Galesburg Animal Hospital, PC
CLIENT REGISTRATION

NAME

First_____Middle Initial_____ Last_____

Spouse: First_____ Middle Initial_____ Last_____

ADDRESS

Street_____City_____ State_____ Zip_____

Email address_____ **Decline Email Reminders** ☐

PHONE NUMBERS

Home(_____)_____ Cell(_____)_____

Spouse's Cell(_____)_____ Emergency(_____)_____

WORK INFORMATION

Employer_____Phone(_____)_____

Spouse's Employer_____Phone(_____)_____

For check writing privileges, please provide the following

SSN_____-_____-_____ Driver's License Number_____ Exp _____

People authorized to make medical and financial decisions for patients on this account besides those above

Name:_____ Phone Number(_____)_____

Name:_____ Phone Number(_____)_____

How did you become aware of our hospital?

□ Referred, Whom may we thank?_____ □Yellow pages □ Google

□Drove by □Facebook □Radio □Website, www.galesburganimalhospital.com

Do you agree to receive text messages to remind you of vaccinations or appointments scheduled? _____

Do you agree to photos being taken of you and or your pets and posted on our website or Facebook? _____

I hereby authorize the veterinarian to examine, prescribe for, and or treat my pets. I assume all responsibility for payment due and give permission for services rendered. We require payment when services are rendered. For your convenience, we accept cash, check, Mastercard, Visa, Discover, American Express, CareCredit, and Scratch Pay. In the event that charges are not paid in full at the time of services please read and agree to the following terms: I assume all responsibility for payment due. I agree to 21% interest per year calculated monthly as 1.75% per month on the unpaid balance, plus the cost of collection fees at up to 50% of the total owing balance.

I verify that all the information provided is accurate and agree to the above terms.

SIGNATURE_____ Date_____