TRI COUNTY
VETERINARY CLINIC

661 Plaza Drive, Fostoria OH 44830
(419) 435-7642

Client Registration Form

Name: ____
(First) (Middle Initial) (Last)

Spouse: ____
(First) (Middle Initial) (Last)

Address: ____
(Street) (City) (State) (Zip Code)

Home Phone: ____________ Cell Phone: ____________ Spouse Cell: ____________

E-Mail Address: ____________________ How did you first hear of us? ____________

Employer: ____________________ Employer Phone: ____________

Employer Address: ____

Spouse's Employer: ____________________ Employer Phone: ____________

Spouse's Employer Address: ____

I hereby authorize the veterinarian to examine, prescribe for, or treat the described pet(s). I assume responsibility for all charges incurred in the care of the animal(s) listed. I also understand that these charges will be paid at the release and that a deposit may be required for surgical treatment. If I fail to pay the outstanding balance within thirty (30) days of due date, a finance charge (interest) of 1.5% per month, or 18% per year will be added to the unpaid balance until paid in full. If my account is not paid within 90 days of due date, it may be referred to a third-party collection agency or sent to small claims court. I understand that I will be charged a returned check fee for each check returned. I will be responsible for any other expenses necessary to collect my account including collection fees, court costs, and attorney fees, should legal action be instituted against me. This signature on file is my authorization for the release of information necessary to prices my claim including employment verification. I have read, understand, and agree to all of the terms set forth above.

Method of Payment: Cash _____ Check _____ Master Card/Visa _____ Discover _____ Care Credit _____

Signature of Owner: ______________________________ Date: ____________

Signature of Spouse/Co-Owner: ______________________________ Date: ____________

See reverse side to complete form

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Pet No. 1 Information

Name: ______________________ Breed: _______________ Color:_____________ Age:______

Intact Male ____ Neutered Male ____ Intact Female ____ Spayed Female ____ Other____

Previous Vet (if applicable): ____

Date of last vaccinations: __________________ Date of last Rabies vaccine: ________________

Any long-term health concerns? ____
____

Current Medications (if applicable): ____

Pet No.2 Information

Name: ______________________ Breed: _______________ Color:_____________ Age:______

Intact Male ____ Neutered Male ____ Intact Female ____ Spayed Female ____ Other____

Previous Vet (if applicable): ____

Date of last vaccinations: __________________ Date of last Rabies vaccine: ________________

Any long-term health concerns? ____
____

Current Medications (if applicable): ________________________________

If you have additional pets, please let us know and we can give you additional forms to fill out.

Please initial to confirm information

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