# LENOIR CITY ANIMAL CLINIC, P.C.

Companion Animal Medicine & Surgery

**CLIENT / PATIENT INFORMATION**

**NAME:**_____
(Last) (First) (Initial)

**SPOUSE'S NAME:**_____

**ADDRESS:**_____

_____
(City) (State) (Zip Code)

**PHONE NUMBERS:** Home:( )_____ Work: ( )_____
Cellular: ( )_____ Pager: ( )_____

E-Mail Address:_____

**REFERRED BY:** Friend:_____
(Friends Name)

Drive By _____ Phone Book _____ Other _____

**PERSON FINANCIALLY RESPONSIBLE:**_____
(Signature)

**********

**PATIENT NAME:**_____ **BREED:**_____

**SEX:** Male_____ Female_____ Spayed/Neutered_____ Color _____

**DATE OF BIRTH:**_____ **TENDENCY TO BITE?** Yes_____ No____

**********

**PATIENT NAME:**_____ **BREED:** _____

**SEX:** Male _____ Female _____ Spayed/Neutered_____ Color_____

**DATE OF BIRTH:**_____ **TENDENCY TO BITE?** Yes_____ No____

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**DO YOU HAVE PET INSURANCE?** YES____ NO ___

**PLEASE NOTE: OUR POLICY IS PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.**

**Method of payment:** Cash: ____ Check: ____ Credit Card:____ Care Credit: ___