PATIENT/CLIENT INFORMATION

Welcome to Mokena Animal Clinic. Thank you for giving us the opportunity to care for your pet(s).

So we may provide you with exceptional service, please share information about you and your pet(s). Our mission is to provide our clients with the very best loving, compassionate veterinary health and wellness care from before hello to beyond good-bye for your best friends.
" We Treat Your Pet Like Family"

CLIENT INFORMATION:

☐Mr. ☐Mrs. ☐Miss ☐Ms. ☐Dr.

Client Name(s):_____

Address:_____County: ☐WILL ☐COOK ☐OTHER

City:_____ State:_____ Zip Code:_____

Home phone: ( )_____ Work phone: ( )_____ Ext_____

Cell phone: ( )_____ EMERGENCY phone #: ( )_____

If you wish to pay by check: Driver's License #_____ State:_____

E-mail address: _____

Would you like to receive vaccination reminders and promotions by e-mail? □ Yes □ No

*Please enroll me as a registered member of the hospital website: □ **Yes** □ No

As a registered member I will be able to:

Check pets' vaccinations status / Request appointments/boarding / Purchase medication/ food refills /Make better decisions about pets' health & well-being / Discover ways to help your pet live a longer & healthier life / Inform if pet is lost/deceased / Notify of address change

Please note: Your privacy is important to us. All information received in all forms and through other communications is subject to our Patient Privacy Policy.

Employer Name: _____

Employer's Address:_____State_____Zip_____

Employer's Phone#: ( )_____

Spouse's Employer Name: _____

Spouse's Employer's Address:_____State_____Zip_____

Spouse's Employer's Phone#: ( )_____

How did you become aware of Mokena Animal Clinic?

☐ Referred by a client; whom may we thank? _____

☐Saw our clinic or sign ☐Yellow Book ☐SBC/DEX ☐ HomePages ☐ Website □Other_____

I hereby authorize the veterinarians of Mokena Animal Clinic, Ltd. to examine, prescribe for, or treat the above described pet(s). I assume responsibility for all charges incurred in the care of this animal. I understand that **ALL CHARGES ARE DUE AT THE TIME SERVICES ARE RENDERED**. There may be a deposit required for surgical procedures. For your convenience, we accept cash, check, debit cards, MasterCard, Visa, Discover, American Express and CareCredit. A $25.00 fee will be added for all returned checks. If fees for professional services are not paid in accordance with the provisions herein, reasonable attorney's fees, plus applicable finance charges can be applied to all amounts that are at least 30-days past due at the rate of 1.5% per month (18% annual rate). **If the account is in default and turned over for collection, I acknowledge that I will be responsible for a $25.00 fee and all reasonable costs associated with effecting collection. I verify that all the information provided is accurate.**

Signature of Client/Owner Date

CONFIDENTIAL