McAfee Animal Hospital

651 Eastport Centre Dr.

Valparaiso, IN 46383

"Where caring and community matter"

Client Information (please print):

Client Name _____ Spouse Name _____

Address _____ City _____ State _____ Zip _____

Primary Phone _____ Secondary Phone _____ DOB _____

Driver License # _____ State _____ Expiration _____

Email Address _____ SSN _____

Emergency Contact _____ Phone _____

Pet Insurance: ◯ Y ◯ N Insurance Provider _____

Payment is due in full at the time service is rendered. This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including billing fees, reasonable attorney fees and costs of collection in event of default. Any financial constraints need to be communicated prior to treatment. I will be using the following method of payment :

Cash _____ Check _____ Credit Card _____ Care Credit _____

SIGNATURE _____ Date _____

Pet Information :

Name of pet _____ Species _____

Age/Date of Birth _____ Breed _____ Color _____

Sex : Male _____ Neutered Male _____ Female _____ Spayed Female _____