Mohawk Animal Hospital

414 W. 7th St.
Sycamore, Ohio 44882

419-927-4343

New/Update Client Form

Welcome and Thank You for choosing us to care for your pet(s). Our hospital policy is to provide your pet with quality care. Please take a few minutes to fill out this client information for you and your pet(s). If you have any questions, please don't hesitate to ask. THANK YOU

Owners Name_____Significant other_____

Address_____City_____State_____

Zip_____County_____E- Mail_____

HOW DID YOU HEAR ABOUT US? Please circle Word of Mouth ● Drove By Clinic

Radio Ad (which station _____) ● Print Ad (where _____) ● Other _____

Home Phone_____ Alt #_____

Cell_____ Cell_____

Work Name_____ Work Name_____

Work Phone _____ Work Phone_____

D L #_____ DL #_____

SS#_____ SS #_____

Date of Birth_____ Date of Birth_____

(SS Number required for both Owner and spouse on any account not paid in full)

Pet Name_____ Pet Name_____

Breed_____ Breed_____

Sex_____Altered Yes_____No_____ Sex_____ Altered Yes_____No_____

Color_____DOB_____ Color_____DOB_____

I hereby authorize the veterinarian to examine, prescribe for, or treat my pet(s). I assume responsibility for all charges incurred in the care of my pets. I also understand that these charges will be paid at the time of release and that a deposit is required for treatment. Unpaid balances over 30 days are subject to interest at 2% monthly. Billing occurs on the 1st of every month. Owner is responsible for all court costs and lawyer fees if account is turned over to collection.

_____ _____ _____

Signature of responsible Owner/agent Signature of responsible Owner/agent Date