Receptionist: _____ Acct.#_____

Wellington Veterinary Clinic, Inc.
45015 St. Rt.18
Wellington, OH 44090

CLIENT REGISTRATION

Thank you for choosing our animal clinic. We pride ourselves in offering high quality medical care and emphasize preventive medicine. We look forward to serving you and caring for your pet's needs for many years to come. Please complete this form so we can accurately enter this information into our files. To open an account with us, you must be *at least age 18* and provide a photo ID, such as driver's license or state I.D.

Owner's Name: _____ Home Phone # (_____) _____

Home Address: _____ Cell Phone # (_____) _____
(Street address)

_____ E-mail Address _____
(Mailing address, P.O. Box if applicable) (For free Internet access to your account & pet reminders)

_____
(City) (State) (Zip)

_____
(County)

Spouse's Name: _____

Employer: _____ Spouse Employer: _____
(Required)

Address: _____ Address: _____
(Street) (Street)

_____ _____
(City, State, Zip) (City, State, Zip)

Work Phone # :(_____) _____ Work Phone # :(____) _____

The following information is required for your account and is strictly CONFIDENTAL:

SOCIAL SECURITY NO.: _____ DATE OF BIRTH: ___/___/____ (Required)
Driver's License #: _____ State _____

How do you plan to pay for today's services? *Circle one:* ***Cash Check Credit Card***
Payment is due in full at the time of service. *We accept cash, checks, and credit cards; VISA, MasterCard, Discover, and we offer* ***Care Credit*** *if you need a payment plan.*

How did you hear about our clinic? Phone Book: _____ Drove By: ____ Clinic Mailing: ___
Other: _____ Referral: _____ *Whom may we thank for referring you?* _____

Do you have a ***GOLDEN BUCKEYE*** Card ***or*** are you at least 65 years of age? *(For our Senior Discount)*
YES _____ NO_____

We pledge to do our very best to care for your pet's health needs. In return we ask you to accept the responsibility for charges incurred in the treatment of your pet and accept that **payment is due when services are rendered**. Please feel free to ask for an **Estimate** prior to providing services. If at anytime you are not satisfied with our service, please let us know. We will be happy to answer your questions.

Agreement Terms: *Balances due over 30 days will be charged a 2%/mo interest charge (24% APR). Checks returned for non-sufficient funds will be charged $30 or 10% returned check fee (whichever is higher) and may be debited from your bank account electronically.*

Additional collection fees will be charged if your past-due account is sent to Collections or Small Claims Ct.

Client Agreement & Signature: _____ **Date**: _____