

Bremen Animal Clinic, P.C.

1971 Douglas Rd
Bremen IN 46506
574-546-2472

Full Name (Primary on Account)_____

Spouse (If applicable)_____

Address_____City_____State____Zip_____

Cell Phone_____Home Phone_____

Email Address_____

Place of Employment_____Phone_____

Spouse's Place of Employment_____Phone_____

Name of Pet/Breed/Date of Birth_____

Color_____Sex_____Spayed/Neutered_____

Known issues or medications_____

Previous Veterinarian_____

Whom may we thank for referring you_____

Authorization: I understand that I/we am/are responsible for all costs of treatments. I hereby authorize the veterinary to administer such medications, perform such diagnostics and procedures as may be necessary for proper medical care. The information on the page and the medical history is correct to the best of my knowledge. I grant the right to the veterinarian to release my pet's medical history and other information about treatment to other veterinary professionals

Service Charge: If I do not pay the entire balance within 25 days of the monthly billing date, a billing fee (\$2.00) and interest charges (2.0% per month) will be added to my account for the current monthly billing period. In the case of a default payment, I hereby promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future accounts.

****Payment in full is expected at the time of service.****

Signature_____Date_____