Welcome to

Cornerstone Animal Clinic

Patient Check-In

Client Information:

Last Name: _____ First: _____ MI: _____ Check here if new Client ☐

Address: _____

Zip: _____ City: _____ State: _____ Phone #:_____

Fax#:_____County:_____Work #:_____

Cell #:_____Spouse:_____Spouse Cell #:_____

Email_____

SSN: _____ AND/OR Driver's License: _____

Preferred Doctor: _____Referral:_____

Date of Birth: _____ Business Referral: _____

1st Patient Information:

Name: _____ Species: _____Check here if new pet ☐

Breed: _____Color Markings: _____ Age: _____ B-day: _____

Sex: Male: ☐ Neutered Male: ☐ Female: ☐ Spayed Female: ☐

2nd Patient Information:

Name: _____ Species: _____Check here if new pet ☐

Breed: _____ Color Markings: _____ Age:_____ B-day: _____

Sex: Male: ☐ Neutered Male: ☐ Female: ☐ Spayed Female: ☐

Payment & Contact Information

Preferred Method of Payment: Cash: ☐ **Credit Card:** ☐ **Check:** ☐ **Care credit:** ☐

Preferred Method of Contact: Cell Phone: ☐ **Home Phone:** ☐ **Email:** ☐ **Work Phone:** ☐

Responsible Party Consent:

I, the undersigned, do hereby certify that I am the duly authorized agent for the animal(s) described above, that I do hereby give Randy Benham, DVM, and his agents, and/or representatives full and complete authority to perform the treatment procedure(s) described and agreed upon to be performed at their discretion. These procedures may be useful to promote the health of the animal(s.) I understand the responsibility of payment for services and medications provided in this office is mine – due and payable at the time services are rendered. Any unpaid balance is subject to handling fees equaling $6.00 each statement period and/or interest equaling 1.5% on your account.

Clients **may be** required to pay a non-refundable deposit equal to the price of the exam plus taxes before scheduling an appointment. If the scheduled appointment is cancelled or no-showed, the amount of the deposit will be forfeited.

Photographs of pets may be taken on behalf of Cornerstone Animal Clinic and can be used for medical record, marketing, or educational purposes.

Please Print Name: _____

Signature: _____Date: _____