VETERINARY HOSPITAL OF DILLON

PATIENT and CLIENT INFORMATION SHEET

Date _____

Name _____ Spouse's Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____ Spouse's Cell Phone _____

Employer _____ Spouse's Employer _____

Work Phone # _____ Email _____

How did you learn about us?

☐ Drove by ☐ Yellow Pages ☐ Website ☐ Referred by _____

PATIENT INFORMATION	Name #1	Name #2	Name #3
Name			
Species	Dog/Cat/Horse	Dog/Cat/Horse	Dog/Cat/Horse
Breed			
Date of Birth			
Color			
Sex	M / F	M / F	M / F
Spayed or Neutered	Y / N	Y / N	Y / N
Last Vaccination Date			

Any previous serious illness or surgeries? _____

Any allergies to vaccinations or medications? ☐ NO ☐ YES

If YES, please explain _____

Any special diet or medications? ☐ NO ☐ YES

If YES, please explain _____

What do you feed your pet? _____

2150 Overland Road
Dillon, Montana 59725
P: (406)683-2385
F: (406)683-2009

info@vethospitalofdillon.com
www.vethospitalofdillon.com

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Financial Policy

- All services must be paid at the time of service. We accept Cash, Local Personal Checks, VISA, MasterCard, Discover, debit cards and CareCredit
- A deposit may be required for major surgery and/or hospitalization at the time of admittance to the hospital
- Emergency cases taken in after hours may require a deposit at the time of admittance to the hospital for intensive treatment to begin
- Monthly payments may be made through CareCredit. An application must be completed and approved by CareCredit prior to your animal's discharge. There is no annual fee and no down payment required. There are interest free options available.

- I request that the Veterinary Hospital of Dillon's doctors and staff perform the services which are necessary for the examination and medical treatment of the animal(s) presented by me. I am the owner or agent for the owner of the described animal(s) and have the authority to execute this consent.
- I understand a written estimate will be provided at my request
- **I assume financial responsibility for all the charges incurred to the patient(s) for services rendered and understand that full payment is required upon discharge.**
- **I prefer to pay by:**

☐ Cash ☐ Check ☐ Credit or Debit Card ☐ CareCredit

Driver's License # _____ Social Security # _____

(at least one or both of these must be completed for payment with Check or CareCredit)

_____ _____

Signature of Owner or Responsible Agent Date

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