

Milan Veterinary Clinic – Michael L. Sweet, D.V.M.

Last Name: _____ First: _____

Street Address: _____ City: _____ Zip: _____

Home Telephone: (_____) _____ Work: (_____) _____ Spouse / Other Name: _____

Your Cell Number: (_____) _____ How did you hear of us?: Yellow Pages - Location - Relative - Friend -

Other: _____ Name of individual we may thank: _____

E-mail Address: _____ Social Security Number: _____

Drivers License: _____ Employer: _____

County: Washtenaw, Monroe, Other: _____ Date of Birth: _____

Children's Names & Ages: _____

Spouse's DL #: _____ Employer: _____ Work #: (_____) _____

Date of Birth: _____ Social Security Number: _____ Cell Phone: (_____) _____

In case of an Emergency, Call (other than you/spouse): (_____) _____ Name: _____

Please complete information for all your pets - Thank You!	Pet #1	Pet #2	Pet #3
Pet's Name			
Species (Canine/Feline/Equine etc.)			
Breed			
Color			
Age or Date of Birth			
Sex			
Spayed or Neutered?			

Reason for Visit : _____

Previous Veterinarian (s) where past records can be obtained, if necessary: _____

Has your pet been treated for any illness this past year?: _____

I ASSUME RESPONSIBILITY for all charges incurred in the care of this/these pet(s). I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment.

PLEASE NOTE: We require 24 hours notice for cancelled appointments. By signing below you agree to pay our current examination fee for late cancellations or forgotten / missed appointments. Service, Billing and Collection Agency fees will apply to unpaid balances.

SIGNED Owner / Responsible Party: _____ **Date:** _____

How will you be paying for your visit today? Cash Check Visa/Master Discover Am. Exp. Debit Card