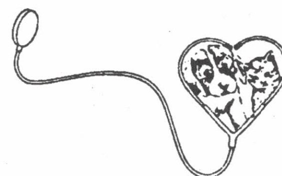
THE MORICHES HOSPITAL FOR ANIMALS

KEVIN G. LYNCH, D.V.M.

214 Main Street, Center Moriches, NY 11934

Telephone: (631) 878-1600



WELCOME

CLIENT INFORMATION

Date ______________

Name (Last Name First) ____

Spouse's Name ____

Address ______________________________ City/State/Zip ____________________

Home Phone ________________________ Cell Phone ________________________

Work Phone ________________________ Employer ________________________

E-Mail Address ____

Emergency contact ____________________ Contact Phone ____________________

How did you learn about our practice? ________________________________

Primary reason for visit. ____

PET INFORMATION

Pet's Name ____________________ Dog ___ Cat ___ Other ______________

Sex ________ Age ________ Birthdate ______________ Breed ______________

Color ____________________ Neutered/Spayed Yes ___ No ___ At what age ________

Pet's Name ____________________ Dog ___ Cat ___ Other ______________

Sex ________ Age ________ Birthdate ______________ Breed ______________

Color ____________________ Neutered/Spayed Yes ___ No ___ At what age ________

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the care of the animal. I also understand that there is no billing and all professional fees are due at the time services are rendered.

We accept cash, credit and debit cards. Personal checks are accepted if imprinted with your name and address and accompanied by a driver's license. All checks will be processed electronically.

Signature of client responsible for pet ____________________________ Date ______________