Cat Clinic Of Central Illinois

2917 W. Springfield Ave. Champaign, IL 61820 Phone: 217/359-8400 Fax: 217/359-8401

New Client Information Form:

Client Name:_____

Address:_____
Street City State Zip Code

Email Address :_____

Phone Numbers:_____
Home Cell Work

Patient Name:_____

Age/Date of Birth:_____

Sex (Circle): Female/Male Previous Surgeries (Circle): Neutered/Intact Other:_____

Breed:_____ Color:_____ Markings:_____

Aggressive (Circle): Yes/No

Reason for being seen:_____

_____

Employer Information:

Name:_____

Address:_____
Street City State Zip Code

Phone:_____Supervisor:_____

How did you hear about us? _____

Payment Information

Full payment is required for all services rendered. WE DO NOT BILL. A service fee of $30.00 will be assessed for all returned checks. Any unpaid balance on the account by the end of the month will incur a service charge of 1.5% per month (18.0%) and an account handling fee of $5.00 per month. Any account with an unpaid balance after 90 days will be referred to a professional collection agency.

_____(Initial) I have read the payment information.