



Brookeville Animal Hospital, LLC

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Client Registration Form

Primary Owner/ Contact-

Name: _____

Address: _____ City: _____ Zip Code: _____

Preferred Number to Call: _____ Best Time: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Secondary Owner/ Contact (if applicable)-

Name: _____

Preferred Number to Call: _____ Best Time: _____

Email Address: _____

May we email you regarding your pet's care and reminders for service due? YES NO

*We will not disclose, sell or otherwise distribute emails, and will not use for purposes other than pet care messages, reminders and newsletters. You may opt out of email newsletters at any time.

Would you like to receive news and specials via Brookeville Animal Hospital E-Newsletter? YES NO

May we use photos of your pet(s) for educational or marketing purposes? YES NO

How did you hear about us? _____ Referred By: _____

Financial Responsibility Agreement- WE ACCEPT VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, CARE CREDIT, CHECK, CASH. I understand that payment is expected at the time services are rendered unless prior arrangements have been made. If a balance is not paid in a timely fashion the client will be responsible not only for the balance due but a monthly billing fee (due to high cost of billing), as well as for any collection and/or reasonable attorney fees that are incurred in the attempt to collect this debt. A \$30.00 fee will be assessed for all returned checks.

Print Name

Signature

Date

For Office Use Only:

Information Checked By: _____ Date: _____