



Massachusetts Veterinary Referral Hospital

INTOWN VETERINARY GROUP

Client/Patient Registration: ID# _____

Last Name: _____ First Name: _____ MI: _____

Address: _____ Town: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Alternate Phone: _____ E-Mail Address: _____

Spouse/Co-owner Name: _____ Work Phone: _____

Address (if different from above): _____ Alt. Phone: () _____

Pet Information

Pet's Name: _____ Breed: _____ Color: _____

Species (circle one): Dog Cat Rabbit Bird Other: _____

Date of Birth ____/____/____ Sex (circle one): Male Female Neutered Male Spayed Female

Referring Veterinarian

Referring Veterinarian: _____ Veterinary Hospital: _____

Address: _____ City/Town: _____ State: _____

Phone: () _____ Fax: () _____ E-Mail: _____

Financial Policy

Payment in full is due when services are rendered. We accept cash, MasterCard, Visa, and Discover. Hospitalized patients require a 75% deposit at the time of admission, based on an estimate provided upon examination by the veterinarian. Written estimates are provided for all hospitalized patients. Estimates are based on your pet's presenting status and are subject to change. In the event of significant changes in your pet's status, a second estimate will be provided and an additional deposit will be required. Any refunds you are entitled to will be processed by original method of payment. We do not issue cash refunds. Payments made in cash will receive entitled refunds by a mailed refund check within 5-7 business days.

I am the legal owner or the representative of the legal owner of the animal being presented and I am over the age of 18 years.

Signature: _____ Date: _____