PLANTATION CENTRE ANIMAL HOSPITAL
6411 PEAKE RD MACON, GA. 31210
(478) 474-3616 (478) 477-7126 Fax
Jeff Davis D.V.M. Jill Lancaster D.V.M. Cindy Brown D.V.M. Shannon Elliott D.V.M.

Owner Information: **Date: _____**

Name: _____ SSN:_____
Last First MI

Address: _____

City: _____ State: _____ Zip: _____

Home # ( )_____ Work# (__)_____ Cell# ( )_____

Email Address: _____

Employer: _____ Address: _____

Spouse's Name: _____ Employer: _____

Spouse's Cell Phone: _____ Work Phone: _____

Pet Information:

Pet Name: _____ Species: Feline Canine Other: _____

Breed: _____ Date of Birth/Age: _____

Color: _____ Sex: Male, Male Neutered, Female, Female Spayed

Previous Veterinarians and Phone Numbers: _____

Vaccination History: (List Dates)

Canine: Rabies: _____ Distemper/ Parvo:_____ Bordetella:_____ HeartwormTest:_____

Feline: Rabies: _____ Distemper (Fvrccp): _____ Leukemia: _____ FeLV/ FIV Test:_____

Please list any **Insurance** and **Medications** your pet is currently on:

_____

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Please list any **Insurance** and **Medications** your pet is currently on:

_____

We accept Visa, Master Card, Discover, American Express, Debit Cards, Checks with proper ID, CareCredit, and Cash.

*Payment is due when services are rendered or when patient is released from the hospital. We **do not** offer billing.*

Patients requiring hospitalization will require a deposit when admitted.

Any balance not paid in full or returned checks is liable to service charges, collection and/or legal fees.

I understand the above hospital policy and accept responsibility for all charges in caring for my pet.

Signature: _____ Date: _____