3% FEE ADDED
TO CREDIT CARD
PAYMENTS

CALVERT WELL PET CLINIC
2240 SOLOMON'S ISLAND ROAD
HUNTINGTOWN, MARYLAND 20639
443-295-7873

CLIENT CHECK IN

PLEASE LET THE RECEPTIONIST KNOW IF YOU OR YOUR PET HAS BEEN HERE BEFORE, EVEN UNDER A DIFFERENT NAME

OWNER:
First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (H) _____ (W) _____ (C) _____

E-Mail Address: _____

PET:
Name: _____ Birth Date/Age: _____

Breed: _____ Color: _____

Species: { } **Canine** { } **Feline** **Sex:** { } **Female** { } **Male**

Spayed/Neutered? { } **YES** { } **NO**

Vaccine History: (Please supply receptionist with a copy of your pet's vaccine and testing history)

What is the reason for today's visit?

_____

_____

I understand that I am financially liable for all charges incurred today for my pet and payment is due in full at time of services.

Signature: _____ Date: _____