

# IDEAL

AUTOMOTIVE SERVICES

Customer Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Email Address \_\_\_\_\_

YEAR \_\_\_\_\_

MAKE \_\_\_\_\_

MODEL \_\_\_\_\_

COLOR \_\_\_\_\_

LICENSE PLATE \_\_\_\_\_



- |  |  |
|--|--|
| <input type="checkbox"/> Change Oil and Filter | <input type="checkbox"/> Check Engine Light On |
| <input type="checkbox"/> Tire Rotation         | <input type="checkbox"/> Engine Running Poorly |
| <input type="checkbox"/> Transmission Service  | <input type="checkbox"/> Low Fuel Mileage      |
| <input type="checkbox"/> Brake Inspection      | <input type="checkbox"/> Vibration or Noise    |
| <input type="checkbox"/> Inspect Tires         | <input type="checkbox"/> _____ Mile Service    |
| <input type="checkbox"/> Pre-Trip Inspection   | <input type="checkbox"/> Replace Wipers        |

Other Services Needed/Description of Problem

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Customer Signature \_\_\_\_\_