



704 Orleans Road  
 Charleston, SC 29407  
 Phone: (843) 766-7387  
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# Animal Medical West NEW CLIENT REGISTRATION

Revised 10-05-03

**Please Print**

Owner's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse/ Other: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Driver's License State & #: \_\_\_\_\_

Address \_\_\_\_\_ Apt. Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Owner's Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

Pager#: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

What time is it best to call about your pet? \_\_\_\_\_ and at what Phone# ? \_\_\_\_\_

In case of EMERGENCY, call: \_\_\_\_\_ at phone#: \_\_\_\_\_

Pet's Name: _____	Species _____	Breed _____
Color _____	Date of Birth _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Neutered/Spayed <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is your pet currently receiving any medication? <input type="checkbox"/> Yes <input type="checkbox"/> No What? _____		
Does your pet have any known drug allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No What? _____		
Name of Previous / Current Vet: _____		

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Color _____	Date of Birth _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
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Does your pet have any known drug allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No What? _____		
Name of Previous / Current Vet: _____		

How did you become aware of our clinic:  Hospital Sign  Yellow pages  Vet Locator  WebSite - [www.amw.petplace.com](http://www.amw.petplace.com)  
 Other, please specify \_\_\_\_\_  
 Individual (someone we may thank) \_\_\_\_\_

**ALL FEES ARE DUE AND PAYABLE UPON COMPLETION OF SERVICES**

Method of payment:  Cash  Check  Credit Card Number  Other Agreed Upon Terms \_\_\_\_\_

I understand that in order to meet certain scheduling requirements, all missed appointments will be considered a "no-show" after 20 minutes unless advance notice is arranged. Clients not appearing for appointments may be assessed up to \$25.00 per incident. I understand every effort will be made to achieve a successful outcome and to provide for all possible safety in hospital care and handling. I hereby authorize this hospital to receive, prescribe for, treat or perform surgery upon the pet(s) listed above. Furthermore, I agree to pay fees for all services rendered at the time the pet is discharged from the hospital or the service is otherwise terminated. I agree to pay for the reasonable costs of collection, attorney fees, and court costs in the event that collection efforts become necessary. I agree that the venue of this action will be in the county where the hospital is located. I understand that veterinary service is provided during nighttime hours as necessary in the judgment of the veterinarian in charge. Continuous presence of qualified personnel may not be provided.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

<b>Clinic Use Only</b>	Drivers license/ID copied or currently on file _____
	Staff check-in Initials _____