

PETCARE

HOSPITAL AND WELLNESS CENTER

Client Registration Form

Owner Name _____ File # _____
Address _____
City _____ Zip Code _____
Home Phone # _____ Cell # _____
Work # _____ How did you hear of us? _____
Spouse or Co-Owner's name _____
Work # _____ Cell # _____
E-mail Address _____
Driver License # _____ State _____ Exp Date _____
Emergency Contact _____ Phone # _____

PET HEALTH HISTORY

Patient Name _____
Dog ___ Cat ___ Other _____
Breed _____
Birth Date _____ Color _____
Male ☐ Neutered ☐
Female ☐ Spayed ☐
Date Last Vaccinated _____
Veterinarian Name _____
City _____ State _____
Phone # _____
Long Term Conditions _____

Current Medications _____

Patient Name _____
Dog ___ Cat ___ Other _____
Breed _____
Birth Date _____ Color _____
Male ☐ Neutered ☐
Female ☐ Spayed ☐
Date Last Vaccinated _____
Veterinarian Name _____
City _____ State _____
Phone # _____
Long Term Conditions _____

Current Medications _____

AUTHORIZATION

I hereby authorize the Veterinarian to examine, treat and prescribe for the pet(s) listed.
☐ *I assume responsibility for all charges incurred in the care of the animal*
☐ *I also understand that these charges will be paid for at the time of visit and prior to release. **We accept Visa, MasterCard, Debit Card or Cash.** Personal checks not accepted.*

To ensure your pet receives the correct medication and dosage, we do not honor online pharmacy requests.

Signature _____ date _____
Owner and/or Responsible Party

Completed by _____