New Client / Patient Registration

Client Information (Must be over 18):

Owner Last Name: Owner First Name:

Spouse First Name: Spouse Last Name:

Street Address:

City: Zip Code:

Primary Phone Number: Secondary Phone Number:

Work Phone Number: Cell Number (Spouse):

Primary Cell Number: Email:

Occupation: Occupation (Spouse):

Referred By:

Patient Information:

Pet's Name: Species:

Breed: Sex: Spayed/Neutered: YES / NO

Color: Birthdate:

Known Allergies:

Please give the date that the following were performed:

Distemper Vaccine: Rabies Vaccine:

Heartworm Test: Currently on preventative?:

Feline Leukemia/ FIV Test: Result:

Feline Leukeima Vaccine:

Major Medical Problems:

Other Pets: Species:

Financial Policy

We can accept cash, checks, Mastercard, Visa, Care Credit, and all other major credit cards as methods of payment. I accept financial responsibility for the treatment of the above named pet. I understand that payment is expected at the time services are rendered. If you have an account with no payment after 60 days, Andover Animal Hospital, Inc., may relinquish your balance to a collection agency. You will then be responsible for all collection fees. Thank you.

Signature of Owner: Date: