

CLIENT & PATIENT REGISTRATION FORM

CLIENT INFORMATION (PLEASE PRINT & BE COMPLETE)

Please Check One: New Client Current Client - New Pet

Name _____
First Middle Initial Last

Address _____
Street City, State, Zip Code County

Home Phone _____ Cell Phone _____ Emergency Phone _____

Employer _____ Work Phone _____

Occupation _____ State/Drivers Lic. # _____

Spouse/Co-Owner's Name _____

Employer _____ Work Phone _____

How did you hear about us? _____

E-mail address (1) _____ E-mail address (2) _____

Would you like to receive reminders by e-mail? Yes No (we are currently taking steps to initiate e-mail reminders)

PET NO. 1 Name _____ Species: Cat Dog Other _____

Breed _____ Sex _____ Spay/Neutered? _____ Color _____

Date of Birth / Age _____ Date Last Vaccinated _____

Where were vaccinations obtained? _____

Significant medical history or recurrent problems? _____

Current Medication (if any) _____

PET NO. 2 Name _____ Species: Cat Dog Other _____

Breed _____ Sex _____ Spay/Neutered? _____ Color _____

Date of Birth / Age _____ Date Last Vaccinated _____

Where were vaccinations obtained? _____

Significant medical history or recurrent problems? _____

Current Medication (if any) _____

I hereby authorize the veterinarians to examine, prescribe for, or treat, the above described pet(s). I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment.

Signature of Owner or Agent _____ Date _____