

NEW CLIENT/NEW PATIENT REGISTRATION

Owner's Name _____ Spouse/Partner _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

Employer's Name and Address _____

Spouse's/Other's Employer & Address _____

In case of EMERGENCY, please call _____ at telephone # _____

Preferred Phone Number for Patient Updates _____

Email Address _____ Email Reminders Opt In? Yes No

Pet's Name _____ Approx. Date of Birth _____

Dog Cat Other _____ Sex: Male Male Neutered

Female Female Spayed

Breed _____ Color _____ Microchip? Yes No

Reason for Visit _____

Previous Animal Hospital where past records may be obtained? _____

Has your pet been treated for any illness in the past year? Yes No

Specify problem(s), medication and dosage, if known _____

Any allergies to medication or reactions to vaccinations? _____ If yes, please explain.

Individual we may thank for a referral? _____

List the names and types of any other animals that you own

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. TO PREVENT THE SPREAD OF DISEASES AND PARASITES, HOSPITALIZED AND BOARDED ANIMALS MUST BE CURRENT ON ALL VACCINES AND FREE OF INTERNAL PARASITES. I authorize the doctor to provide vaccines and parasite control as needed for my pet.

Owner or Responsible Party _____ Date _____

WE REGRETFULLY INFORM YOU THAT WE CANNOT ACCEPT PERSONAL CHECKS AS A FORM OF PAYMENT FOR THE INITIAL VISIT