

Welcome!

Account # _____

Thank you for giving us the opportunity to care for your pet(s). We strive to provide the highest quality healthcare available with compassion and convenience.

Please fill out form completely.

REGISTRATION

Date _____
Guardian Name Mr. Mrs. Miss Ms. Dr. _____
Address (Residence) _____ Mailing Address (If different) _____
City _____ State _____ Zip _____ Email _____
Name of Spouse/Other _____
Children (Names & ages) _____
Employer Name & Address _____ Work Phone _____
Home Phone _____ Spouse Work Phone _____ Cell Phone(s) _____
Emergency Contact Person (other than yourself) _____ Phone _____

How did you learn of our hospital? Yellow Pages Sign Other _____
Someone we may thank? _____

PATIENT INFORMATION

Name _____ Dog Cat Other _____ Breed _____
Color _____ Date of Birth/Age _____ Sex _____ Spayed/Neutered? Yes No
Name _____ Dog Cat Other _____ Breed _____
Color _____ Date of Birth/Age _____ Sex _____ Spayed/Neutered? Yes No
Name _____ Dog Cat Other _____ Breed _____
Color _____ Date of Birth/Age _____ Sex _____ Spayed/Neutered? Yes No
Previous veterinarian where records may be obtained _____
Has your pet been treated for any illness within the last 12 months? Yes No
Specify problem(s), medication and dosage if known: _____

A deposit is required on all surgical, dental and medical procedures. I hereby authorize the veterinarian to examine, prescribe for and treat the above described patient(s). **I ASSUME FULL FINANCIAL RESPONSIBILITY FOR ALL CHARGES INCURRED IN THE CARE OF THIS PATIENT AND AGREE TO PAY IN FULL AT THE TIME SERVICES ARE RENDERED.**

Signature of Guardian _____ Date _____

Driver's License Number(required if paying by check) _____ Issuing State _____

Preferred method of Payment MC VISA Cash Check