CLIENT REGISTRATION FORM

Please Check One: ____ New Client ____ Current Client-New Pet
Name_____
(First) (Middle Int.) (Last)
Address_____
(Street) (City, State, &zip code)
Home Phone ( ) _____Cell Phone ( ) _____

Driver's License#_____

Employer_____ Work Phone ( ) _____

Spouse or co-owner _____

E-mail Address (clinic use only)_____

Employer_____ Work Phone ( ) _____

How did you first hear of us?_____
(e.g.: Person's Name, Yellow Pages, Sign, Etc.)

PET INFORMATION

Name_____ Primary Diet Fed: _____

Species: Cat_____ Dog_____ Other_____

Breed _____ Color _____ Birth Date _____

Sex : Female_____ Male _____ Spayed / Castrated : Yes_____ No _____

Dates of last Vaccinations: Distemper_____ Rabies _____

Previous Veterinarian _____

Any Previous Major Health Problems? _____

Current Medications _____

Reason for visit _____

ALL FEES ARE DUE AT THE TIME THE PATIENT IS RELEASED. ON YOUR REQUEST, WE WILL PROVIDE YOU WITH A WRITTEN ESTIMATE OF FEES FOR ANY TREATMENT NECESSARY. IF YOUR PET IS HOSPITALIZED, WE WILL REQUIRE A DEPOSIT.

Signature of Owner or Agent _____Date _____