NEW CLIENT REGISTRATION

OWNER INFORMATION:

NAME: ____
ADDRESS: _________________________________ APT #: ___________________
CITY/STATE/ZIP: ____
HOME PHONE: _________________________ EMPLOYER: ___________________
CELL PHONE: ________________________ WORK NUMBER: __________________
EMERGENCY CONTACT: _______________ EMERGENCY NO. _________________
E-MAIL ADDRESS: ____
(In order to receive reminders about your pet's vaccinations, a working e-mail is required.)
WHOM MAY WE THANK FOR THIS REFERRAL? ____________________________

SPOUSE/CO-OWNER INFORMATION:

NAME: ____
ADDRESS: _________________________________ APT #: ___________________
CITY/STATE/ZIP: ____
HOME PHONE: _________________________ EMPLOYER: ___________________
CELL PHONE: ________________________ WORK NUMBER: __________________

PET INFORMATION

PET ONE:

NAME: ________________________
SPECIES: _________ SEX: _________
BREED: ________________________
COLOR: ________________________
SPAYED/NEUTERED: _____________
DATE OF BIRTH: ________________
DATE OF LAST VACC: ___________
WHERE GIVEN: _________________
CURRENT MEDICATIONS: _________
____
LONG TERM PROBLEMS: __________
____
REASON FOR VISIT: _____________
____

PET TWO:

NAME: ________________________
SPECIES: _________ SEX: _________
BREED: ________________________
COLOR: ________________________
SPAYED/NEUTERED: _____________
DATE OF BIRTH: ________________
DATE OF LAST VACC: ___________
WHERE GIVEN: _________________
CURRENT MEDICATIONS: _________
____
LONG TERM PROBLEMS: __________
____
REASON FOR VISIT: _____________
____

I HEREBY AUTHORIZE THE VETERINARIAN(S) TO EXAMINE, PRESCRIBE FOR, AND TREAT THE ABOVE DESCRIBED PET(S). I ASSUME ALL RESPONSIBILITY FOR CHARGES WILL BE PAID AT THE TIME OF RELEASE AND THAT A DEPOSIT MAY BE REQUIRED FOR THE EMERGENCY OR SURGICAL TREATMENT OF SAID PET(S), OR ANY OTHER INSTANCES THAT THE VETERINARIAN(S) DEEM FIT.

SIGNATURE OF OWNER/AUTHORIZED AGENT: ____________________________
DATE SIGNED: ____

I.D. copied for internal use only by: __________