



NEW CLIENT REGISTRATION

Thank you for giving us the opportunity to care for your companion(s)!
So we may better become acquainted, please complete all of the following:

Owners Information

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

Spouse Name: _____ Spouse Number: _____

How did you hear about our hospital? Sign/Drive By
 Mailing Yelp Online Reviews Website

Another Client? (Whom may we thank?) _____

Companion 1

Name: _____

Species: Canine Feline Other

Sex: Male Neutered Female Spayed

Breed: _____

Date of Birth: _____

Color/Markings: _____

Companion 2

Name: _____

Species: Canine Feline Other

Sex: Male Neutered Female Spayed

Breed: _____

Date of Birth: _____

Color/Markings: _____

Last known date of Vaccinations: _____

Has your pet ever shown any aggressive behavior during an exam before: YES NO

Any known allergies to vaccines or medication: _____

Are there any previous or current medical conditions: _____

I understand there will be an initial consultation fee and agree to this fee. It is understood that a treatment plan will be presented to me that will include any additional recommended treatments, diagnostics, or procedures and all cost associated with those services. I understand that no guarantee or assurance can be made as to the results that may be obtained. It is thoroughly understood that I assume all risks involved with any treatments, neurosurgeries, or procedures.

I have read and agree to the above statement: _____

Professional fees are due at the time services are rendered. We accept Cash, Check, Visa, Mastercard, American Express, Discover, Care Credit and Money Orders.