

NEW CLIENT REGISTRATION

CLIENT INFORMATION

DATE _____

Name _____ Spouse or co-owner _____

Address _____ City _____ State _____ Zip _____

Phone _____ Work Phone _____ Cell phone _____

SS # _____ DL # _____ State _____

All fees are due at the time services are rendered. All past due balances are subject to finance charges. Clients are responsible for all charges. Any account that remains unpaid may be subject to collection and/or attorney fees at client's expense.

Please indicate method of payment: Cash/check _____ Mastercard _____ Visa _____ Discover _____

How did you find out about our hospital? Location _____ Yellow pages _____ previous client _____

Personal recommendation (*Whom may we thank?*) _____

PATIENT INFORMATION

	PET #1	PET #2	PET #3
NAME			
BREED			
DATE OF BIRTH			
COLOR			
SEX: SPAYED OR NEUTERED?			

YOUR PET'S VACCINATION HISTORY

RABIES			
DISTEMPER COMBINATION			
LEUKEMIA			
KENNEL COUGH			
HEARTWORM TEST/ PREVENTION			

Our pet is a: member of the family _____ child's pet _____ Backyard pet _____

Any previous serious illnesses or surgeries? _____

Any allergies to vaccinations or medications? _____

Is your pet on any special diets or medications? _____

Would you like to be present during treatment to your pet? Yes _____ No _____

Client signature _____ Date _____