



New Client Registration Form

Welcome!

"Caring for pets and the people who love them"

Client Name		Preferred method of contact:	
Street Address		Home #	
City	State, Zip	Cell #	
Spouse/Co-owner		Work#	
E-mail	Emergency Contact Name	Emergency Contact Phone	
Co-owner home #		Co-owner cell #	
Co-owner work #		Co-owner email	

Patient Information

Name	Species	Breed	Age	Gender	Spayed or Neutered?	Vaccine Records Available?

I understand that professional fees are due at the time that services are rendered.
 (We accept payment by cash, check, Master Card, Visa, Discover and American Express credit cards)

To accept payment by check, we will need the following information:

Client: Driver's License # _____ State _____ Expiration Date _____

Co-owner: Driver's License # _____ State _____ Expiration Date _____

Who may we thank for referring you to our hospital?

- | | | |
|--|---|-----------------------------------|
| <input type="checkbox"/> Individual (Name) _____ | <input type="checkbox"/> Saw the Hospital | <input type="checkbox"/> Mailer |
| <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Internet | <input type="checkbox"/> Dog Park |
| <input type="checkbox"/> Auction Prize | <input type="checkbox"/> Other | |

At times, we may take photos of your adorable pet for our website or Facebook page.

Please indicate if we have your permission to do so: Yes No

Signature _____ Date _____