New Patient & Client Registration Form

Please complete this form to help us provide the best possible care for your pet

Owner / Client Information

Primary Owner Name: _____ **Date:**_____

Co-Owner / Secondary Contact: _____

Street Address:_____

City:_____**State:**_____ **Zip Code:**_____

Primary Phone: _____[ ] Cell [ ] Home [ ] Work

Secondary Phone:_____ [ ] Cell [ ] Home [ ] Work

Email Address: _____

Patient (Pet) Information (list additional pets on back of page)

Previous Veterinary Clinic / Hospital: _____**Phone**: _____

Pet Name: _____**DOB:**_____ **Sex:** M F **Neutered:** Y N

Species: [ ] Dog [ ] Cat [ ] Other: _____ **Breed:** _____

Pet Name: _____**DOB:**_____ **Sex:** M F **Neutered:** Y N

Species: [ ] Dog [ ] Cat [ ] Other: _____ **Breed:** _____

Financial & Privacy Policy

Please initial and acknowledge each section below

____I understand payment must be made in full at time services are rendered. We accept cash, checks, and major credit/debit cards (except for AMEX)

_____Appointments cancelled with less than 24 hours notice, or missed entirely, will incur a no-show fee

____ Late arrivals are subject to a fee and may need to be rescheduled

_____Please allow up to 24 hours for medication refills

____To ensure your pet's current treatment plan remains safe and effective, they must have had an exam in our office in the past 12 months for us to refill any prescriptions or therapeutic diets

_____I consent to my information being shared with adoption agencies and rescues

____We do not deal directly with outside pharmacies, please request a written prescription at time of exam

Client Signature: _____ **Date:**_____

By signing below, you acknowledge that you are the legal owner (or authorized agent) of the pet named above, agree to the above terms stated, and authorize medical treatment for your pet.