



♥ WELCOME! ♥

## CLIENT REGISTRATION

**The Staff of our hospital thank you for the opportunity to provide veterinary care for your pet family member. Please take a few moments to fill out this form as completely as possible.**

<b>Client Name: <i>please print all entries</i></b> <input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	<b>CONTACT INFORMATION</b>
<b>Mailing Address:</b>	<b>Home Phone:</b>
street	<b>Work Phone (Self):</b>
city state zip	<b>Work Phone (Spouse/Co-owner):</b>
<b>Employer:</b>	<b>Cellular Phone (Self):</b>
<b>Spouse's/Co-owner's Name:</b>	<b>Cellular Phone (Spouse/Co-owner):</b>
<b>Spouse's/Co-owner's Employer:</b>	<b>E-mail (for email reminders and news):</b>
<b>Professional fees are due at the time services are rendered. If you wish to pay by check, credit card, bank or debit card, please complete the following:</b>	<b>Emergency Contact Name and Number:</b>
<b>Driver's License:</b>	<b>How did you hear about us?</b>
<b>Social Security Number:</b>	<input type="checkbox"/> <b>Is there someone we may thank?</b> - Individual _____
<b>Other Information we should know:</b>	<input type="checkbox"/> Saw our hospital <input type="checkbox"/> Website <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Newspaper Article or Advertisement <input type="checkbox"/> Other _____

Welcome sent:

Registered By

(Office Use Only) Client ID:

PET # 1	PET # 2
<b>Pet's Name:</b>	<b>Pet's Name:</b>
<b>Date of Birth or Age:</b>	<b>Date of Birth or Age:</b>
<b>Species:</b> <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other	<b>Species:</b> <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other
<b>Breed:</b>	<b>Breed:</b>
<b>Sex:</b> <input type="checkbox"/> Male (neutered? <input type="checkbox"/> yes <input type="checkbox"/> no) <input type="checkbox"/> Female (spayed? <input type="checkbox"/> yes <input type="checkbox"/> no)	<b>Sex:</b> <input type="checkbox"/> Male (neutered? <input type="checkbox"/> yes <input type="checkbox"/> no) <input type="checkbox"/> Female (spayed? <input type="checkbox"/> yes <input type="checkbox"/> no)
<b>Color/Markings:</b>	<b>Color/Markings:</b>
<b>Vaccinations were last given by (clinic name):</b>	<b>Vaccinations were last given by (clinic name):</b>
<b>Date:</b>	<b>Date:</b>
<b>Allergies or Long-term Medical Problems:</b>	<b>Allergies or Long-term Medical Problems:</b>