Patient Registration Form

Owner's Last Name: ____ First Name: _____________________________

Spouse/Co-Owner: ____

Home Address: ____ APT#_______________

City: ____ State: __________ Zip Code: _________________

Phone #: (Primary)_________________________________ (Secondary) _____________________________________

Email Address: ____
(email address used for reminders & special email promotions only)

How did you hear about us? **Please circle**

Sign Internet Facebook Event(please list)__________________ ; Other(name)___________________

Friend or family member who referred you?____

Pet's Name: ____ Date of Birth/Age: ______________________________

Species: Canine Feline Other (circle one)

Breed: ____ Color: ____

Male / Female Neutered/Spayed: Yes / No Microchipped: Yes / No Has your pet been vaccinated: Yes / No

Is your pet currently on any medications? Yes / No
If vaccinated elsewhere - previous veterinarian/s where records may be requested? _____________________________

Phone Number for those records: ____

*Please note that payment in full is expected at time of service. We accept Visa, Master Card, American Express, Discover, Care Credit, Cash and personal checks (w/ a driver's license).

I understand that failure to make payment may result in collection processing and that I am responsible for any additional fees due any agency/attorney. Also, there will be a $35 charge for returned checks.

We love to show off our patients photos on social media, please follow us on Facebook, Instagram and Twitter for pet health information, specials and great pet photos. If you would prefer we did not include your pet’s photo initial here to Decline____

Client Signature: ____ Date: ___________________