



CLIENT REGISTRATION FORM

Owner Information

Name: _____	Spouse/Partner: _____
	(Relation): _____
Street Address: _____	City, State: _____
Zip: _____	Email Address: _____
Email is how we do our major form of communication. You will miss out on reminders if one is not filled in.	
Preferred Contact Number: _____	
Secondary Contact Number: _____	

Pets Name: _____	DOB: _____	
Species: _____	Breed: _____	Color: _____
Gender: _____	Please circle if Spayed/Neutered: Yes/ No	
Known Allergies or Reactions (if any): _____		
Current Medications (if any): _____		
Pets Name: _____	DOB: _____	
Species: _____	Breed: _____	Color: _____
Gender: _____	Please circle if Spayed/Neutered? Yes/ No	
Known Allergies or Reactions (if any): _____		
Current Medications (if any): _____		

To help prevent the spread of infectious diseases, ALL patients must be current on all vaccinations.

I understand every effort will be made to achieve a successful outcome, and to provide for all possible safety in hospital care and handling. I hereby authorize this hospital to receive, prescribe for, treat or perform surgery on patients. Furthermore, I agree to pay fees for services at the time the pet is discharged from the hospital or the service is otherwise terminated. I agree to pay for the reasonable costs of collection in the event that collection efforts become necessary. There will be a service charge for any check returned unpaid. I understand if I no call no show for my appointment I am expected to pay a no-show fee. Spouses and partners listed on form have equal authority to make medical decisions and to accept treatment plans. I understand that I am financially responsible for payment, whether the services are approved by me or my spouse/partner.

Signature of Owner: _____