

NEW CLIENT REGISTRATION FORM

Owner's Name: (Ms Mrs Mr) _____
Last First

Spouse/Other (Ms Mrs Mr) _____
Last First

Address: _____ City _____ State ____ Zip _____

Mailing Address: _____ City _____ State ____ Zip _____
(If different than above)

Home Phone: _____ Cell Phone: _____

Email Address: _____

Driver's License # _____ Exp. Date _____ State ____ DOB _____
(If you are writing a check we need a copy of your driver's license as well)

Occupation/Employer: _____

Work Phone: _____ Ext _____

Where do you prefer to be contacted? Home _____ Work _____ Other _____

Preferred Method of Payment: CASH () CHECK () CREDIT CARD () CARE CREDIT ()

How did you hear about us?

Google () Facebook () Pet Store () Veterinarian () Friend () Other () _____

Name of person(s), store or Dr who referred you: _____

All fees are due at the time services are rendered.

On your request we will provide you with a written estimate of fees for any hospital treatment, emergency care, or surgery. A deposit prior to treatment may be required depending on the amount of the estimate.

I acknowledge that by setting an appointment for my pet, being seen by the Veterinarian, and receiving treatment and/or medications, I am responsible for the costs incurred. Payment will be made at the time of services.

Signed: _____ Date: _____