New Client and New Patient Registration Form

Owner's Name _____ Co-owner's Name _____

Cell Phone _____ Home Phone _____ Work Phone _____

Street Address _____ City _____ State _____ Zip Code _____

E-Mail Address _____ Emergency Contact (Name/Phone) _____

How did you hear about us? __ Sign __ Google __ Yellow Pages __ Friend __ Other (please list _____)

If a friend referred you, please let us know whom we may thank _____

Pet's Medical History

Pet's Name _____ Reason for today's visit _____

Type: __ Dog __ Cat __ Rabbit __ Bird __ Reptile __ Other (please list _____)

Birthdate or approx. age _____ Sex: __ M __ F Neutered/Spayed: __ Yes __No

Breed _____ Color/Pattern _____

List all vaccinations your pet has had, and dates last received _____

Do you have your pet's medical records with you? __ Yes __ No May we request transfer of your pet's records? __ Yes __ No

Previous Veterinary Care Provider (Name/Phone) _____

If you have pet insurance, please list your provider _____

What percentage of time is your pet outdoors? _____ Indoors? _____

Is your dog on heartworm prevention? __ Yes __ No Type _____ Date last given _____

Is your dog or cat on flea/tick prevention? __ Yes __ No Type _____ Date last given _____

Has your cat ever been tested for FeLV and FIV? __ Yes __ No Date/Results _____

List any allergies or previous vaccine reactions your pet has/had _____

List any previously diagnosed medical conditions your pet has/had _____

List any medications your pet currently takes _____

Do you have other pets? __ Yes __ No (If yes, please list names, types, and ages) _____

Please read the following carefully, and sign below:

We take pride in the quality of service and medical care we provide you and your pet. To maintain these high standards and keep your costs at a reasonable level, WE DO NOT BILL FOR SERVICES RENDERED. Full payment is due when services are rendered. For your convenience, we accept cash, Visa, Mastercard, Discover, American Express, and CareCredit. WE DO NOT ACCEPT CHECKS.

I agree to pay for all professional services and medications as they are rendered. The information on this form is true and accurate. I further agree that in the case of nonpayment, a finance charge of 1.75% per month (21% per annum) will be added to the balance due. In addition, a monthly billing fee of $3.50, as well as any collection fees or attorney fees will be paid by me.

Signature _____ Date _____