



New Client Registration Form

Welcome to our Hospital! Our mission is:
To be there for our clients by providing unparalleled medical care in an atmosphere of uncompromising compassion so our patients live long and happy lives.

Owner's Information

Owner's Last Name		Owner's First Name	
Street Address			City, State & Zip
Primary Phone	Secondary Phone	Work Phone	
E-mail Address			
Occupation		Employer	
Co-Owner's Last Name		Co-Owner's First Name	
Co-Owner's Phone		Relationship to Owner	
Co-Owner's Email Address			
Emergency Contact		Emergency Contact's Phone	

How did you learn about our Hospital?

<input type="checkbox"/> Google Search <input type="checkbox"/> Facebook <input type="checkbox"/> Twitter <input type="checkbox"/> Drove By <input type="checkbox"/> Phone Book				
Local Shelter/ Rescue	Personal Referral		Other	

Patient #1 Information

Name		Species		Breed	
Age/DOB	Sex	Spayed/Neutered		Color	
Length of Time Owned	Microchip Number	Previous Veterinarian		Date of Last Exam	
Does this pet have insurance? If yes, what company?					

Patient #2 Information

Name		Species		Breed	
Age/DOB	Sex	Spayed/Neutered		Color	
Length of Time Owned	Microchip Number	Previous Veterinarian		Date of Last Exam	
Does this pet have insurance? If yes, what company?					

We pledge to do our very best to care for your pet's health needs. In return we ask that you accept the responsibility for charges incurred in the treatment of your pet. Payment is required at the time services are rendered. We accept credit cards, cash, personal checks, and CareCredit. We may also require deposits for certain services. By signing this form, you agree to pay for all charges incurred in the care of this/these pet(s).

Owner's Name		Date
Owner's Signature		