WELCOME

New Client Registration

Last Name_____First Name_____

Spouse (Co-Owner) First Name_____Last Name_____

Street Address_____

City_____State_____Zip Code_____

Home Phone:_____ Cell Ph:_____Co-Owner Cell Ph:_____

Email Address:_____

Pet Portal sign up – 24/7 access to your pet's medical records and our online store
(We do not sell this information)

Name of previous hospital_____

How did you learn about our hospital?_____

Your Pet's Information

	1st Pet	2nd Pet	3rd Pet	4th Pet
Name				
Species				
Breed				
Color				
Sex	F SPAY ☐ M NEUTER ☐	F SPAY ☐ M NEUTER ☐	F SPAY ☐ M NEUTER ☐	F SPAY ☐ M NEUTER ☐
Age/DOB				

Authorization:

I/We hereby authorize the veterinarian to examine, prescribe for or treat my pet(s). I/we assume full responsibility for all charges incurred in care of this/these animal (s). I/we also understand that charges will be paid in full at the time of discharge and that a deposit may be required for certain surgical treatments or other procedures.

Signature of owner:_____Date:_____

Signature of co-owner:_____Date:_____