

FAMILY PET HOSPITAL REGISTRATION FORM

CLIENT INFORMATION

Client Code and Start Date (we will enter) _____
Last Name _____ First Name(s) _____
Address _____ Apt _____ Lot _____ Unit _____
City, State, ZIP _____
Home Phone () _____ Work Phone () _____
Cell Phone () _____ E-mail address _____
May we send you information by E-mail? Yes No
HOW DID YOU HEAR ABOUT US? _____

PATIENT INFORMATION

Name _____ Canine Feline Other _____ Age/DOB _____
Breed _____ Color _____ Male Female Spayed Neutered
Rabies Tag No. (if known) _____ Microchip No. (if applicable) _____
Known Allergies? _____

Name _____ Canine Feline Other _____ Age/DOB _____
Breed _____ Color _____ Male Female Spayed Neutered
Rabies Tag No. (if known) _____ Microchip No. (if applicable) _____
Known Allergies? _____

Name _____ Canine Feline Other _____ Age/DOB _____
Breed _____ Color _____ Male Female Spayed Neutered
Rabies Tag No. (if known) _____ Microchip No. (if applicable) _____
Known Allergies? _____

Name _____ Canine Feline Other _____ Age/DOB _____
Breed _____ Color _____ Male Female Spayed Neutered
Rabies Tag No. (if known) _____ Microchip No. (if applicable) _____
Known Allergies? _____

FINANCIAL RESPONSIBILITY STATEMENT

I state that I am responsible for the care of this pet and accept total responsibility for the financial payment of work done on my pet, whether I bring my pet in or someone else does this for me. Payment is due at the time services are rendered. I further agree to pay all finance charges, collection costs, attorneys' fees and any other costs that may be incurred to enforce collection of any amount outstanding.

Driver's License No. and State _____ SS# _____
Place of Employment _____
Signature _____ Date _____

LET US COPY YOUR PET'S VACCINATION AND HEALTH RECORDS. THANKS. WE WILL RETURN YOUR COPIES.