



New Client / Patient Registration

Today's Date: ____ / ____ / ____

Owner (1st) FULL name: _____

Owner (2nd) or other contact person: _____

Home Address: _____

City: _____ ST: _____ Zip: _____

Date of Birth (Owner) ____ / ____ / ____ Home Phone (____) ____ - ____

Cell (1st) (____) ____ - ____ Cell (2nd) (____) ____ - ____

Email: _____

Are you or your spouse **Active Military or Retired Veteran** with proper ID: _____

Pet(s) information

Pet's Name: _____ Age/DOB _____

(Circle all that apply) Dog / Cat / Other _____ Male / Female Neutered / Spayed

Breed: _____ Color: _____ Microchipped? YES NO

Pet's Name: _____ Age/DOB _____

(Circle all that apply) Dog / Cat / Other _____ Male / Female Neutered / Spayed

Breed: _____ Color: _____ Microchipped? YES NO

Pet's Name: _____ Age/DOB _____

(Circle all that apply) Dog / Cat / Other _____ Male / Female Neutered / Spayed

Breed: _____ Color: _____ Microchipped? YES NO

Prior Veterinary Hospital/Clinic to call for Pet's medical/vaccine history: _____

****All payments are due at the time of services rendered.** We accept: Cash,, ALL major Credit Cards as well as Care Credit and Trupanion Express. You can apply for **Care Credit** in office and be approved in as little as 10 minutes!

I have read and understand the above statement and agree to all terms therein.

Signature: _____

We like to take photos of your amazing pet to show them off on our social media pages.

Initial here for **"YES"** _____ If you prefer not to allow us to take photos, just initial here for **"NO"** _____