



NEW CLIENT REGISTRATION FORM

Client Information:

Primary Guardian: _____ Co-Guardian: _____

Address: _____ City, State, Zip: _____

Primary Phone: _____ Alternate Phone: _____
Circle: Home Work Cell Home Work Cell

Email: _____ Occupation: _____

How did you hear about us? _____

Current / Previous Veterinary Clinic: _____

Were you referred here by your veterinarian? Y N Name: _____

Patient Information:

Pet Name: _____ Species: Canine Feline

Breed: _____ Sex: M F Spayed/Neutered? Y N

Date of Birth/Age: _____ Microchip ID: _____

Color & Identifying Markings: _____

Is your pet currently on any medications? Y N Please List: _____

Has your pet ever had a severe allergic reaction to anesthesia, vaccination, medication or food?

Has your pet ever had a severe illness or surgery? _____

FEE POLICY

**All new client exams start at \$150 and all fees must be paid in full at the time services are rendered.
A \$40 missed appointment fee will be assessed for all cancellations made less than 24 hours in advance.**

I have read and understand the above fee policy. I accept financial responsibility for all charges incurred in the care of my pet.

I give the veterinarian permission to examine, treat, and/or medicate my pet.

I consent to the use of alternative medical therapies for my pet, including but not limited to:
acupuncture, chiropractic, herbs, homeopathy, flower essences and nutritional supplements.

Signature of Owner or Authorized Agent

Date