



NEW CLIENT REGISTRATION FORM

Primary Guardian: _____ Co-Guardian: _____

Address: _____ City, State, Zip: _____

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

Email: _____ Occupation: _____

Providing an email will allow us to send you important clinic updates and seasonal newsletters. If you would prefer not to receive these, please leave the field blank.

How did you hear about us? _____

Current Primary Veterinary Clinic: _____

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

Would you like to receive reminders from us? **Y N**

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 \$165 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