COMPANION ANIMAL H0SPITAL

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Client/Patient Registration

Owner's Name____File #__________

Co-Owner's Name____

Address____

City______________________________State____________Zip____________

Home Phone #_________________________Cell #________________________

Owner's Employer__________________________E-Mail____________________
Work Phone#_________________okay to call work? ______Yes______No

How did you find our clinic:_____________________Personal Ref.____________

Pet's Name___________________Breed________________Color____________

Sex: M or F Spayed _______Neutered_______ Birthdate_____/____/_____
Previous Vaccine History
Rabies____/___/____ 1yr or 3 yr Dapl/Parvo____/___/____ Corona ___/______
Fecal____/___/____ Bordetella____/___/____Heartworm Test____/___/____pos or neg
Lymes___/___/____ Deworm___/__/____
Feleuk/FIV Test___/___/____pos or neg FDRCP____/___/____ Feleuk ___/___/____
FIV ___/___/____ Deworm___/___/____
Previous Veterinarian____
Please list any major problems your pet has had___________________________

CAPSTAR WILL BE GIVEN IF YOUR PET HAS FLEAS. THIS IS FOR GROOMING, BOARDING AND BATH DAYS.

Please read the following statement carefully and sign below: I REALIZE THAT FULL PAYMENT IS DUE WHEN SERVICES ARE RENDERED. Payment can be in the form of a check, cash or major credit card. I am responsible for all charges that are incurred on behalf of my pets. At my request, I will be provided with a written fee estimate in case of hospitalization or long term treatment. A deposit may be required in cases of hospitalization and the balance will be paid when current treatment is complete. My Signature signifies my agreement to abide by the above terms.

SIGNATURE____DATE____________
PLEASE BRING IN A COPY OF VACCINE HISTORY FROM YOUR PREVIOUS VET ALONG WITH THIS REGISTRATION FORM
Revised 10-18-10 cpc