NEW PATIENT REGISTRATION

Your Name _____HomePhone_____
Address_____
City _____ State _____ Zip Code _____
Cell Phone _____Driver's License #_____
Employer_____Work Phone _____
Spouse/Partner _____
Spouse's Employer_____Work Phone_____
Spouse's Cell _____
*Email _____

How did you hear about us? (Circle one): **Referred by**_____
Location **Internet** **Previous Client**

*Please enroll me as a registered member of the hospital website: □ **Yes** □ No
As a registered member I will be able to:

- Request appointments/boarding
- Purchase medication/food refills
- Receive clinic announcements
- Inform if pet is lost/deceased
- Notify of address change

*Please subscribe me to the **FREE** Pet Living & Wellness Newsletter: □ **Yes** □ No
Please note: Your privacy is important to us.
All information received in all forms and through other communications is subject to our **Patient Privacy Policy.**

PET INFORMATION

Pet's Name _____Breed_____
Age/DOB _____Color_____
Dog / Cat / Other _____ □Male □Female
Neutered Yes □No

Pet's Name _____Breed_____
Age/DOB _____Color_____
Dog / Cat / Other _____ □Male □Female
Neutered Yes □No

Pet's Name _____Breed_____
Age/DOB _____Color_____
Dog / Cat / Other _____ □Male □Female
Neutered Yes □No

All payments are due at the time of services rendered.

We accept cash, checks & all major credit cards.
I have read and understand the above statements and agree to all terms therein.

Signature: _____

Date: _____