Family Pet Clinic
Client Registration Form

All information below *MUST* be completed.

Owner Name:_____
Physical Address:_____
City: _____ State _____ Zip:_____
Mailing Address:_____
City: _____ State_____ Zip:_____
Home Number: _____ Cell Number:_____
Work Number:_____
DL #:_____ SSN:_____
EMAIL_____
Spouse's Name:_____ Spouse Cell#_____
How did you hear about us?_____

Pet Information:

Pet's Name:	**Sex**:	**Spayed or Neutered?**	**Species:**	**Breed:**	**Color:**	**Age or DOB:**
		Yes or No				
		Yes or No				
		Yes or No				
		Yes or No				
		Yes or No				

Does your pet have any allergies to vaccines, medications, or anything else?_____
_____
Is your pet on any medications? If so, please list:_____
_____
From what clinic/phone number may we obtain your records? _____
_____

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet(s). This form also serves my permission to release medical records if necessary or requested, and waives confidentiality of the medical record. I assume full responsibility for any and all charges incurred in the care of this animal. I also understand that these charges WILL BE PAID AT TIME OF SERVICES RENDERED and that a deposit may be required for surgical treatment or hospitalization of any kind. Due to an overwhelming amount of returned checks, we can no longer accept ANY checks from non-established clients. We apologize in advance for any inconvenience.

Please *circle and initial* your method of payment today:

MC VISA DISCOVER AMEX CASH CARECREDIT

Signature of Owner:_____ Date:_____