NEW PATIENT REGISTRATION

Your Name: _____Spouse:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home: _____ Cell Phone #1: _____

Work: _____ Cell Phone #2: _____

*Email: _____

By providing an email address, you will be enrolled in our Clinic's "Pet Portal". This will allow you access to your pet's records at all times and will allow you the ability to request appointments and medicine refills.

All information received in all forms and through other communications is subject to our **Patient Privacy Policy.**

Are you a Senior Citizen? Yes No
Are you a First Responder? Yes No
Are you Military? Yes No

How were you referred? Google Facebook Another Clinic: _____

Friend: _____ Other: _____

PET INFORMATION

Pet's Name: _____ Age/DOB: _____ Color: _____

Breed: _____ Dog / Cat / Other: _____ Male / Neuter / Female / Spayed / Unknown

Pet's Name: _____ Age/DOB: _____ Color: _____

Breed: _____ Dog / Cat / Other: _____ Male / Neuter / Female / Spayed / Unknown

Pet's Name: _____ Age/DOB: _____ Color: _____

Breed: _____ Dog / Cat / Other: _____ Male / Neuter / Female / Spayed / Unknown

Pet's Name: _____ Age/DOB: _____ Color: _____

Breed: _____ Dog / Cat / Other: _____ Male / Neuter / Female / Spayed / Unknown

All payments are due at the time of services rendered. Please provide your Driver's License.

We accept cash, all major credit cards, and Care Credit which can be approved in as little as 10 minutes.

I have read and understand the above statements and agree to al terms therein.

Signature: _____ Date: _____