# Welcome

## Client Registration

Date:_____

Mr. Mrs.
Miss Ms. Dr.:_____
(Last Name) (First Name) (Middle Initial)

Spouse/Other:_____
(Last Name) (First Name) (Middle Initial)

Address:_____ City:_____ State:_____ Zip:_____
(Street and Street Number)

Home Phone:_(_____)_____ Cell Phone:_(_____)_____ E-mail:_____

Employer:_____ Work Phone:_(_____)_____

Employer (Spouse):_____ Work Phone:_(_____)_____

Emergency Contact:_____ Phone:_(_____)_____

Who referred you to our practice? ☐ Self ☐ Other _____
(Name)

Preferred method of payment: ☐ Cash ☐ Check ☐ Mastercard/Visa
Please provide driver's license number if paying by check or credit card. State _____ # _____

*Please note that payment is due in full when services are rendered.*

## Patient Information

Name:_____ Species: ☐ Canine ☐ Feline ☐ Other _____

Date of Birth: ____/____/____ Breed: _____

Sex: M F Has your pet been spayed or neutered? _____ If so, when? _____

Color: _____ Other identifying marks: _____

Where did you acquire your pet? ☐ Shelter ☐ Breeder ☐ Pet Shop ☐ Relative ☐ Other

How long have you had this pet? _____ Has your pet been to the veterinarian before? _____

Has your pet been vaccinated? _____ If so, when, and for what? _____

Does your pet go outdoors? _____ ☐ In and Out ☐ Lives Outdoors ☐ Strictly Indoors

Is your pet presently taking medication? _____ If so, what? _____

Does your pet have any allergies? _____ If so, what kind? _____

What is your pet's diet? ☐ Dry ☐ Canned ☐ Semi Moist ☐ Other _____

Does your pet have any behavior problems? ☐ Housebreaking ☐ Biting ☐ Destructive Habits ☐ Running Off
☐ Fighting ☐ Other _____

Are there other pets in your household? _____ If so, what? _____

Other comments or previous medical problems:_____

_____