PAWS Veterinary Center
300 East River Road, Tucson, Arizona 85704
(520) 888-7297 PawsTucson.com

New Patient Registration

Thank you for giving PAWS the opportunity to care for your pet.
We'll be happy to answer any questions you have about your pet's health.
To insure the best care possible, please take time to fill in this form completely. Thank you!

YOUR NAME:		SPOUSE/CO-OWNER:		
ADDRESS:	APT/UNIT:	CITY:	STATE	ZIP CODE:
PHONE NUMBER: OK TO TEXT (IF APPLICABLE)? SELECT LOCATION		ALT. PHONE: OK TO TEXT (IF APPLICABLE)? SELECT LOCATION		
EMAIL ADDRESS:		EMERGENCY CONTACT NAME & PHONE NUMBER:		

Please note: Your privacy is important to us. All information received in all forms and through other communications is subject to our Privacy Policy & Red Flag Law.

How did you learn about our veterinary center? (Please check all that apply)

☐ Google Ad ☐ General Web Search ☐ Facebook ☐ Home Show ☐ Pinterest ☐ Yelp ☐ Event
☐ Road Sign ☐ Location ☐ Newspaper/Magazine ☐ Dex/Phone Book ☐ Recommendation
☐ SAVSEC ☐ VSCOT ☐ Referral by another hospital/doctor ☐ Other

If recommendation/referral, who may we thank?

INITIALS	**PLEASE INITIAL EACH OF THE FOLLOWING:**
	I hereby authorize the veterinarian to examine, prescribe for, or treat my pet (s).
	I am aware that trained personnel will not be here beyond regular hours.
	I understand it is my responsibility to inform the veterinary care team with relevant information regarding my pet's health, diet, medications, supplements, and/or treatments. Serious and sometimes fatal consequences can result from result withholding medical information.
	I am aware that **ALL PAYMENTS ARE DUE AT TIME OF SERVICES RENDERED.** We accept cash, AZ checks with an AZ ID, CareCredit, Visa, Discover, Mastercard and American Express. P.A.W.S. does not have a payment plan available but we do offer CareCredit through an independent creditor for your convenience.
	In the event the account is placed for collections and/or litigation, I am aware that I am responsible for all costs.
	I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid at the time of release and a deposit may be required for drop-off/surgical treatment.
	I am 18 (or older) and agree by signing below that I am the person responsible for the care and well-being of my pet(s).
	I am under 18 and/or not the owner of the animal. I am aware that P.A.W.S. provides a Power of Attorney letter that must be signed for me to provide care for the pet(s) being seen today.

SIGNATURE OF OWNER/CO-OWNER:	DATE:

You are taking the best care of your best friend: Your veterinary practice is accredited by the American Animal Hospital Association. Unlike human hospitals, veterinary practices are not required to be accredited. Your veterinary team volunteered to be evaluated on about 900 standards of veterinary excellence in order to become accredited. AAHA-accredited practices are recognized among the finest in the profession and are consistently at the forefront of advanced veterinary medicine.

AAHA ACCREDITED
The Standard of Veterinary Excellence

Pet's Information

If bringing in more than one pet for appointment, please fill out a separate form for each pet

PET'S NAME:	AGE/DOB:	SEX: ◯ MALE ◯ MALE NEUTERED ◯ FEMALE ◯ FEMALE SPAYED

SPECIES:	BREED:	COLOR:

IS YOUR PET: INDOOR ONLY ◯ OUTDOOR ONLY ◯ INDOOR/OUTDOOR ◯	IS YOUR PET MICROCHIPPED? SELECT	MICROCHIP NUMBER, IF KNOWN:

APPROXIMATE HOURS SPENT OUTDOORS:	NATIVE TO ARIZONA? SELECT	IF NOT NATIVE, WHERE BORN?	PLACES PET TRAVELS:

IS YOUR PET ON ANY SUPPLEMENTS OR MEDICATIONS? SELECT	IF YES, PLEASE LIST:

PREVIOUS MEDICAL ISSUES (IF NONE, LEAVE BLANK):

PLEASE LIST ANY KNOWN ALLERGIES TO VACCINES OR MEDICATIONS (IF NONE, LEAVE BLANK):

BEHAVIOR: HAS YOUR PET EVER SHOWN AGGRESSION TOWARDS HUMANS OR ANIMALS? HAS YOUR PET SHOWN ANY RECENT BEHAVIOR CHANGES? PLEASE EXPLAIN.

PLEASE LIST ANY RECENT CHANGES IN HOME ENVIRONMENT (IF NONE, LEAVE BLANK):

OTHER PETS? SELECT	IF YES, PLEASE LIST:

If you are a referral patient to PAWS, it is important to note that for all routine care services, including laboratory services, vaccinations, surgeries, and dentistry, will be transferred back to your primary care provider. To facilitate informed and exceptional care for your pet, PAWS Integrative Veterinary Center will contact your primary care veterinarian via fax or phone, summarizing your pet's alternative or rehabilitative evaluation.

I would like my records sent to my primary care veterinarian or hospital.

My primary care veterinarian or hospital is:

To the best of my knowledge, ALL information about my pet is represented correctly.

SIGNATURE OF OWNER/CO-OWNER:	DATE:

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Thank you for trusting PAWS Veterinary Center with your pet's care. We value our relationship and are committed to providing you and your pet with comprehensive, quality care. In light of this, we seek to maximize your care experience, minimize waiting time, and create a more efficient and harmonious environment. Being late to a scheduled appointment can negatively impact your and your pet's experience, the care of our subsequent patients, and our team. Insufficient notice to cancel or reschedule impacts our ability to accommodate appointments for pets/owners with urgent scheduling needs. These mutual goals require us to establish a Tardy/No-Show/Insufficient Cancellation Agreement as follows:

Client Responsibilities:

Please be prompt. Clients arriving 15 minutes or more after their appointment time may be asked to reschedule, wait for the soonest available appointment, and/or be offered a drop-off appointment.

Should you need to cancel or reschedule, please contact our office as soon as possible, and no later than 24 business hours prior to your scheduled appointment. We understand same-day scheduled appointments are not able to provide 24-hour notice.

Clients who fail to give appropriate cancellation/rescheduling notice will be asked to provide a $65 deposit credit prior to scheduling their next appointment. Excessive no-shows will result in client dismissal.

Please verify and update contact information, so we can effectively communicate reminders or scheduling updates.

Please respond to appointment confirmation correspondence.

PAWS Responsibilities:

We will make every effort to be timely and respectful of your time. Should patient emergencies impact our schedule, we apologize in advance for any inconvenience and will keep you informed.

We will provide comprehensive reminders via email, text messaging, phone calls and mailed post cards depending upon set preferences, scheduled services and timing.

We understand extenuating circumstances can impact your ability to keep appointment times/provide sufficient cancellation notice. Our hospital administrator is available to discuss these situations and assist in future scheduling and potential waiving of the deposit credit.

We thank you in advance for your understanding and cooperation and trust this agreement will foster the best care for our clients and patients.

I understand and agree to the Tardy/Cancellation/No-show Policy.

Signature Date