CLIENT REGISTRATION FORM

TODAY'S DATE _____

OWNERS FIRST & LAST NAME _____

TITLE (MR. MRS. MISS. MS.DR.) _____

ALTERNATE/EMERGENCY CONTACT NAME & PHONE NUMBER _____

MAILING ADDRESS _____

CITY _____ POSTAL CODE _____

HOME NUMBER _____ WORK NUMBER _____

CELLULAR NUMBER_____

WOULD YOU LIKE TO BE NOTIFYED BY E-MAIL ABOUT PATIENT REMINDERS? YES or NO
E-Mail:_____

Is there someone we may thank for referring you? _____OR how did you find out about us?

PATIENT INFORMATION

PATIENT NAME:_____ BREED:_____

MICROCHIP#:_____ COLOUR:_____

BIRTH DATE:_____ FEMALE/MALE_____NEUTERED OR SPAYED_____
DO YOU HAVE PET INSURANCE?YES/NO WOULD YOU LIKE TO INQUIRE ABOUT IT? YES / NO

PREVIOUS CLINIC NAME AND TELEPHONE NUMBER:_____

PERMISSION TO CONTACT PREVIOUS CLINIC FOR RECORDS: YES or NO

SIGNATURE OF OWNER: _____

PATIENT HISTORY, SUCH AS ALLERGIES, HEART CONDITION, THYROID DISEASE, SPECIAL DIET

ETC:_____

VACCINATION HISTORY, LAST DATE OF VACCINATION:_____

All payments are due at the time of services rendered.
We accept cash, debit, visa and mastercard. I have read and understand the above statements and agree to all terms therein.
Signature:_____ Date:_____