



New Patient Registration

Client Name (Owner): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Spouse: _____ Spouse Phone: _____

E-mail: _____

(Please check if you do not wish to receive clinic updates and appointment confirmations via e-mail)

How did you hear about our clinic?

Drive by Google Yellow Pages Website OurTown

Money Mailer Shelter Equitrade Barter Company Tradebank

Family/Friend _____ Other _____

Pet Information

Name: _____ **Age/DOB:** _____ **Color:** _____

Please circle one: **Species:** Dog Cat **Breed:** _____

Sex: Neutered Male Spayed Female Intact Male Intact Female

Microchip? Yes No **Microchip Number:** _____

Brand of Food: _____ Heartworm/Flea Control: _____

Last Vaccinations: Date: _____ Where? _____

Name: _____ **Age/DOB:** _____ **Color:** _____

Please circle one: **Species:** Dog Cat **Breed:** _____

Sex: Neutered Male Spayed Female Intact Male Intact Female

Microchip? Yes No **Microchip Number:** _____

Brand of Food: _____ Heartworm/Flea Control: _____

Last Vaccinations: Date: _____ Where? _____

ALL PAYMENTS ARE DUE AT THE TIME OF SERVICES RENDERED

I understand the above statements and agree to all terms therein. I agree that all the information is correct to the best of my knowledge. The signature below gives Family Pet Hospital permission to any and all necessary treatment (in case of an emergency) when the owner cannot be contacted prior to necessary services.

Signature: _____ **Date:** _____

We accept cash, checks, care credit and all major credit cards. A Wellness Financing Plan is available for major procedures exceeding \$200.