

NEW PATIENT REGISTRATION

Your Name _____
Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Cell Phone #1 _____
Work Phone _____ Cell Phone #2 _____
*Email _____
Employer _____ Driver's License# _____

*Please enroll me as a registered member of the hospital website: **Yes** No

As a registered member I will be able to:

Check pet's vaccinations status | Request appointments/boarding | Purchase medication/food refills
Make better decisions about pet's health & well-being | Discover ways to help your pet live a longer & healthier life |
Inform if pet is lost/deceased | Notify of address change

*Please subscribe me to the **FREE** Pet Living & Wellness Newsletter: **Yes** No

Topics of Interest: Dogs Cats Horses Birds Rodents Dr/Member Announcements.

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

PET INFORMATION

Pet's Name _____ Age/DOB _____
Breed _____ Dog / Cat / Other _____
 Male Female
 Male / Neuter Female / Spay Color _____

Pet's Name _____ Age/DOB _____
Breed _____ Dog / Cat / Other _____
 Male Female
 Male / Neuter Female / Spay Color _____

Pet's Name _____ Age/DOB _____
Breed _____ Dog / Cat / Other _____
 Male Female
 Male / Neuter Female / Spay Color _____

Pet's Name _____ Age/DOB _____
Breed _____ Dog / Cat / Other _____
 Male Female
 Male / Neuter Female / Spay Color _____

All payments are due at the time of services rendered.

We accept cash, checks, all major credit cards, & Care Credit which can be approved in as little as 10 minutes.
I have read and understand the above statements and agree to all terms therein.

Signature: _____ Date: _____