Pets R Family Veterinary Hospital

CLIENT/PATIENT REGISTRATION

Owner Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email Address: _____

May we send reminders to you via text or email? Text _____ Email _____ I prefer regular mail only _____

Employer: _____ Phone Number: _____

Referred By: _____

Please list anyone else who can make medical decisions regarding your pet(s):

Name: _____ Phone Number: _____

Pet's Name: _____

Breed: _____ Color: _____ Age: _____

Date of Birth (if known): _____ Sex: Male/ Female Altered: Yes/ No

Current Diet: _____

Current Medications (including heartworm and flea prevention): _____

_____

Name of Previous Veterinarian: _____ Phone Number: _____

Previous Medical Conditions or Surgeries: _____

_____

I hereby authorize Pets R Family veterinarians to examine, prescribe for, and treat my pet(s). I assume responsibility for all charges incurred. I understand payment is due at the time of service.

_____ _____

Client Signature Date