

NEW PATIENT REGISTRATION

Your Name _____
Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Cell Phone #1 _____
Work Phone _____ Cell Phone #2 _____
*Email _____

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

As a registered member I will be able to:

- Check pets' vaccinations status
- Request appointments/boarding
- Purchase medication/food refills
- Make better decisions about pets' 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 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

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

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

Pet's Name _____ Age/DOB _____
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All payments are due at the time of services rendered.

We accept cash, checks, MasterCard and Visa.

I have read and understand the above statements and agree to all terms therein.

Signature: _____ Date: _____