



NEW PATIENT REGISTRATION

Your Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone #1 _____

Work Phone _____ Cell Phone #2 _____

*Email _____ How Did You Find Us? _____

*Please enroll me as a registered member of the hospital website: **Yes** No
As a registered member I will be able to:

I 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 Birds Reptiles 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 _____
Dog / Cat / Other _____ Breed _____ Color _____
 Male Neutered Male Female Spayed Female
Does Your Pet Have A Microchip? Yes No Microchip Number _____

Pet's Name _____ Age/DOB _____
Dog / Cat / Other _____ Breed _____ Color _____
 Male Neutered Male Female Spayed Female
Does Your Pet Have A Microchip? Yes No Microchip Number _____

Pet's Name _____ Age/DOB _____
Dog / Cat / Other _____ Breed _____ Color _____
 Male Neutered Male Female Spayed Female
Does Your Pet Have A Microchip? Yes No Microchip Number _____

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: _____