

NEW PATIENT REGISTRATION

Your Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone #1 _____

Work Phone _____ Cell Phone #2 _____

*Email _____

Referral Source? _____

*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
- I Request appointments/boarding
- I Purchase medication/food refills
- I Make better decisions about pets' health & well-being
- I Discover ways to help your pet live a longer & healthier life
- I Inform if pet is lost/deceased
- I 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 _____
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 _____
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

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: _____