Milan Area Animal Hospital

517 West Main Street
Milan, Michigan 48160
PH: 734- 439-CARE (2273)

Client Registration Form

Thank you for giving us the opportunity to care for your pet.
To ensure the best care possible, please take the time to fill in this form.

OWNER INFORMATION

Last Name: _____ First Name: _____ Drivers License # _____

Last Name: _____ First Name: _____ Drivers License # _____

Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Other Phone: _____

Email Address: _____

Contact Preference ☐ Phone ☐ E-Mail ☐ US Mail

How you found us: ☐ Internet Search ☐ Website ☐ Facebook ☐ Friend _____

PET(S) INFORMATION

Name: _____

Species: ☐ Canine ☐ Feline ☐ Other*

**Describe:* _____

Sex: ☐ Male ☐ Female

Spayed/Neutered: ☐ Yes ☐ No

Date of Birth/Age: _____

Breed: _____

Color: _____

Name: _____

Species: ☐ Canine ☐ Feline ☐ Other*

**Describe:* _____

Sex: ☐ Male ☐ Female

Spayed/Neutered: ☐ Yes ☐ No

Date of Birth/Age: _____

Breed: _____

Color: _____

AUTHORIZATION

I authorize Milan Area Animal Hospital to use pictures of my pet for educational and/or promotional purposes ☐ YES ☐ NO

I hereby authorize the veterinarian at Milan Area Animal Hospital to examine, treat and prescribe for the above described pet(s). I agree to assume responsibility for all charges incurred in the care of this animal. I understand that all charges incurred in the treatment of my pet will be paid in full at the time of discharge and that Milan Area Animal Hospital does not bill or offer payment plans. I also understand that an estimate of the fees for services will be provided to me at my request, and that I am encouraged to discuss all fees for care before services are rendered.

I have read, understand and agree with the above information.

Signature: _____ Date: _____