CRYSTAL SPRINGS PET HOSPITAL

Client Registration

DATE: _____

NAME: _____ **SPOUSE/OTHER:** _____

HOME ADDRESS: _____

City: _____ **Zip Code:** _____

HOME NUMBER: _____ **CELL NUMBER:** _____

What phone number is BEST to call? _____ **What time?** _____

Emergency telephone number _____

EMAIL (PLEASE PRINT CLEARLY): _____

EMPLOYER INFORMATION

Name: _____ **Work number:** _____

Street address: _____ **City:** _____ **Zip code:** _____

PATIENT INFORMATION

Patient (pet's) name: _____ **Date of birth:** _____

Dog ____ **Cat**_____ **Other**_____ **Sex: Male**____ **Female**____ **Neutered/Spayed** ____

Breed: _____ **Color:** _____

Does your pet have a microchip? _____

Do you have other pets? _____

Reason for today's visit? (Use reverse side if needed) _____

_____

Known allergies? _____ **Current medications?** _____

Has your pet been treated for any illness? _____

Previous veterinarian(s) where records can be received if necessary: _____

_____

How did you hear of us? Yelp____ **Yellow pages**____ **Referral** _____

All services are to be paid for at time of service

Payment method: Cash__ Check__ VISA___ MC __ AMX__ Discover ___ Care Credit____

I AUTHORIZE TREATMENT FOR THE PATIENT(S) NAMED ABOVE AND ACCEPT RESONSIBILTY FOR THE CHARGES INCURRED AT CRYSTAL SPRINGS PET HOSPITAL.

***Signature of owner or responsible party*:** _____