# CRYSTAL SPRINGS PET HOSPITAL

*Client & Patient Registration*

## OWNER INFORMATION

First Name _____

Last Name _____

Address _____

City/State _____

Zip _____

Phone # _____ Alt # _____

Email _____

Enable Texts Y ☐ N ☐

## PATIENT INFORMATION

Name _____

Date of Birth (mm/dd/yyyy) _____

Breed _____ Color _____

Male ☐

Female ☐

Neutered / Spayed Y ☐ N ☐

Microchip # _____

## ADDITIONAL INFORMATION

Other / Past Hospitals _____

_____

Current Medications _____

_____

Known Allergies _____

**PLEASE READ**

**I authorize treatment for the patient(s) named above and accept responsibility for the charges incurred at Crystal Springs Pet Hospital.**

**Signature** _____ **Date** _____