CHEWS LANDING VETERINARY HOSPITAL

CLIENT REGISTRATION FORM

NAME:_____
Last First

ADDRESS:_____
Street City, State, Zip

DRIVER'S LICENSE # _____ SPOUSE _____

PHONE # _____ CELL # _____

WORK # _____ EMAIL _____

HOW DID YOU HEAR ABOUT US? _____

WHO REFERRED YOU TO US? _____

PET NO. 1	PET NO.2
NAME _____	NAME _____
BIRTHDATE/AGE _____	BIRTHDATE/AGE _____
SPECIES: CAT__ DOG__	SPECIES: CAT__ DOG__
OTHER_____	OTHER_____
BREED: _____	BREED: _____
SEX___ NEUTERED? _____	SEX___ NEUTERED? _____
COLOR _____	COLOR _____
REASON FOR VISIT _____	REASON FOR VISIT _____

_____ _____

I HEREBY AUTHORIZE THE VETERINARIAN TO EXAMINE, PRESCRIBE FOR, OR TREAT THE ABOVE PET(S). I ASSUME THE RESPONSIBILITY FOR ALL CHARGES INCURRED IN THE CARE OF THIS ANIMAL. I ALSO UNDERSTAND THAT THESE CHARGES WILL BE PAID AT THE TIME OF RELEASE. ANY UNPAID BALANCE WILL BE CHARGED A MONTHLY SERVICE AND HANDLING FEE. A DEPOSIT MAY BE REQUIRED FOR HOSPITALIZATION OR SURGICAL TREATMENT.

SIGNATURE OF OWNER OR AGENT _____

WE ACCEPT VISA, MASTERCARD, DISCOVER, CARE CREDIT, CASH, AND CHECKS