ELTINGVILLE VETERINARY PRACTICE

AAHA ACCREDITED The Standard of Veterinary Excellence

NEW CLIENT REGISTRATION

Welcome! We know your pet's health is important an we thank you for trusting us to care for them. To help us provide the best care possible, please take a few moments to fill out this form completely. Thank you!

Owner Information

☐MR.☐ MRS. ☐MS.☐ DR. Last Name:_____ First Name:_____
☐MR.☐ MRS. ☐MS.☐ DR. Last Name:_____First Name:_____
Address: _____Apt #:_____City: _____
State: ___ ZIP: ____ Telephone/Home: _____ Cell: _____
Emergency contact(name/relationship/phone number):_____
_____
E-Mail Address:_____(used only for patient communications)
Employer: _____Work Phone: _____
How did you learn about our clinic: ☐ Sign outside ☐ Facebook
☐ Recommendation: _____ ☐ Website ☐ Other:_____

Authorized Agent if Owner NOT Present

Last Name: _____First Name: _____
Address: _____Apt #:_____City: _____
State: _____ ZIP:_____Telephone/Home: _____
Cell: _____ Emergency: _____
Employer: _____ Phone: _____
Address: _____City: _____State: ____ ZIP: _____

Patient Information

Patient Name: _____ ☐ Dog ☐ Cat ☐ Other: _____
Breed: _____Color: _____ Birthdate/Age:_____
☐ Male ☐ Neutered ☐Female ☐ Spayed

Please check (✓) any symptoms or problems that you have noticed about your pet:

☐ Behavioral Problems	☐ Lack of Appetite	☐ Sneezing
☐ Bleeding Gums	☐ Limping	☐ Thirst and or Urination Increased
☐ Breathing Problems	☐ Loss of Balance	☐ Vomiting
☐ Coughing	☐ Scooting	☐ Weakness
☐ Diarrhea	☐ Scratching	☐ Other: _____
☐ Eye Bulging or Bloodshot	☐ Seems Depressed	☐
☐ Gagging	☐ Shaking Head	☐

Consent and Authorization

I hereby authorize the veterinarian to examine, prescribe for, and/or treat the above described pet I assume full responsibility for all charges incurred for the care of this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment.

Signature of Owner: _____ Date: _____
Method of Payment: ☐ Cash ☐ Check ☐ Mastercard ☐ Visa _____