

VERANDAH PET HOSPITAL

CLIENT REGISTRATION FORM

NAME _____ SPOUSE _____

Additional person(s) authorized to make decisions for my pet(s) _____

MAILING ADDRESS (street) _____

(city) _____ (state) _____ (zip) _____ Primary Address? Y / N

NORTHERN ADDRESS (street) _____

(city) _____ (state) _____ (zip) _____

PHONE (Primary) Home / Cell (CIRCLE ONE) _____ Home/ Cell/ Work (CIRCLE ONE) _____

PHONE (Spouse Primary) Home / Cell (CIRCLE ONE) _____ Fax Number _____

E-Mail Address _____

EMPLOYER _____ May we call you at work? Yes / No

SPOUSE'S EMPLOYER _____ PHONE _____

PET INFORMATION

PET'S NAME _____ DOG() CAT() OTHER() _____

BREED _____ BIRTHDATE or AGE _____

COLOR(S) _____ SEX _____ SPAYED or NEUTERED?

Does your pet have a microchip - ID Chip? _____ Chip number# _____

DATE & TYPE OF LAST VACCINATIONS _____

WHERE WERE THESE VACCINATIONS GIVEN? _____

CURRENT MEDICATIONS? _____

ALLERGIES or SENSITIVITIES _____

CURRENT FOODS (DRY & CANNED FOOD, TREATS, ETC) CONSUMED IN A 24 HOUR PERIOD: _____

PAST MEDICAL PROBLEMS OR SURGERIES? _____

CURRENT HEARTWORM AND FLEA PREVENTATIVES: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

Pet's Insurance: Insurance Carrier _____ Policy # _____

Payment in full is due at the time of each visit, please feel free to ask for a written estimate of charges.

Signature _____ Date _____