

## Client Registration Form

(for office use only) Client Number: \_\_\_\_\_

Dr. Mr. Mrs. Ms. Miss (please circle one)

Rank if Active Military: \_\_\_\_\_

Last Name: \_\_\_\_\_ ( Jr. Sr. ) First Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

State: \_\_\_\_\_ Driver's License#: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ (By: \_\_\_\_\_)

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name of Spouse or Significant Other: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

State: \_\_\_\_\_ Driver's License # \_\_\_\_\_ Social Security Number: \_\_\_\_\_ (By \_\_\_\_\_)

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse or Significant Other is authorized to present my pet for care, obtain medical information about my pet and make treatment decisions for my pet. Yes No (circle one) Initial: \_\_\_\_\_

### Pet Information

(for office use only) Patient Number # \_\_\_\_\_ Microchip: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Species: Canine \_\_\_ Feline \_\_\_ Other (specify): \_\_\_\_\_ Breed: \_\_\_\_\_

Sex: Male \_\_\_ Neutered \_\_\_ Female \_\_\_ Spayed \_\_\_ Color: \_\_\_\_\_

I authorize Advanced Veterinary Hospital to examine, treat and prescribe for my pet. I assume responsibility for all charges incurred and understand that all fees must be paid for at the time services are provided or at discharge. I understand that while an estimate may be given all potential fees for medical care cannot be anticipated and that fees may exceed quoted estimates if dictated by standards of medical practice. Deposits may be required for surgery or hospitalization. Any account that is not settled satisfactorily including checks returned for insufficient funds will be turned over for collection and/or prosecuted to the fullest extent of the law to include any and all collection and prosecution costs.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_