All Critters Animal Hospital

Client & Patient Registration Form

CLIENT INFORMATION

Last Name:_____ First Name: _____

Address:_____ City: _____ Postal Code:_____

Primary Contact: *Name:* _____ *Phone:* _____

Spouse's Contact: *Name:* _____ *Phone:* _____

Emergency Contact*: Name:*_____ *Phone:* _____

E-Mail Address:_____

How did you become aware of our hospital? _____

PATIENT INFORMATION

	Patient 1	**Patient 2**	**Patient 3**	**Patient 4**
Pet's Name				
Species				
Breed				
Color				
Date of Birth				
Sex				
Spayed/Neutered				
Date last Vaccinated				

Has your pet had any previous illnesses or surgeries?

_____

Has your pet had any allergies to vaccinations or medications?

_____

Is your pet currently on Pet Health Insurance?

_____

Previous veterinary care for your pet has been provided by:

_____

I assume full responsibility for all fees incurred in the care of my pet(s). I also understand that these fees will be payable at the time the services are rendered and that a deposit may be required for the veterinary care of my pet(s). We accept Visa, MasterCard, American Express, Debit and Cash as forms of payment.

☐ I authorize the use of photos of my pet to be used by All Critters Animal Hospital for social media or promotional use.

_____ _____

Client Signature Date