Patient Registration Form

Welcome to Compassionate Care Veterinary Hospital. Thank you for giving us the opportunity to serve your pet's medical needs. Our goal is to serve both you and your pet. Please let us know if there is anything we can do to make you or your pet more comfortable during your visit to our hospital.

Please fill out our registration form. Tell us about you on this side and about your pet on the other side. If you need any assistance please ask one of our veterinary receptionists.

Client Name: ____
Last First

Spouse Name: ____
Last First

Home Address: ____
Street City State Zip

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ______________________ Spouse Cell or Work: ______________________

What is the best number to reach you regarding updates on your pet? ☐ Home ☐ Work ☐ Cell

Best email address to contact you: ____

How would you prefer receiving reminders for your pet's annual exams / vaccinations? ☐ Email ☐ Post Card

Can we tell you about our *Well Pet Plan* program for your dog or cat?	Yes ☐	No ☐

How did you hear about us?

☐ Referred by another client – clients name: ____

☐ Yellow Pages Book ☐ Yellow Pages Online

☐ Referred by rescue group: ____

☐ Referred by another veterinarian: ____

☐ Online search engine: ____

☐ Saw the building or outdoor sign from road

☐ Other: ____

ACKNOWLEGEMENT OF FINANCIAL RESPONSIBILITY: This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered at the time of service. I am also responsible for reasonable attorney's fees and cost of collection in the event of default. I further understand that if payment becomes 30 days past due, delinquency charges at the lesser of the rate of 1 ½% per month, 18% per annum or the maximum allowable rate by law, which will be due on delinquent amounts from the date the payment was due.

Signature ______________________________ Date ______________________

Please turn form over to fill out your pet's information.

Compassionate Care
VETERINARY HOSPITAL

Patient Registration Form - *Pet Information*

Your Pet's Information:	**Pet #1**	**Pet #2**
Pet Name:		
Chronic Medical Conditions: Example: Diabetic / Seizures		
Species: Example: Canine / Feline		
Breed: Example: Poodle / Siamese		
Color:		
Birthdate or Approximate Age:		
Sex: Please circle one	**Male / Female**	**Male / Female**
Spayed or Neutered?	**Yes / No**	**Yes / No**
Microchip: Number if known	**Yes / No** #____________________	**Yes / No** #____________________

Does your pet become nervous or bite while visiting the veterinarian? If yes please describe: ____________________

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Is there anything else you would like us to know about your pet? For example, any past surgeries, special diets, or medications your pet is taking?

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Has your pet had any adverse effects to vaccines or medications? ____________________

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If necessary may we contact your pet's previous veterinarian for additional information regarding your pet's medical history? If yes then please list the practice name and phone number.

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Thank You for your time! Please return this form to one of our veterinary receptionists.

FOR HOSPITAL USE ONLY	
Create Account:	Pet Picture:
New Client Package:	Record Vaccination History: