

# NEW PATIENT REGISTRATION

Your Name(s): \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone #1: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Cell Phone #2: \_\_\_\_\_  
\*Email: \_\_\_\_\_

Please note: Your privacy is important to us. All information received in all forms and through other communication is subject to our Patient Privacy Policy.

## PET INFORMATION

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Pet's Name: \_\_\_\_\_ Age/Date of Birth: \_\_\_\_\_  
Species: Dog / Cat / Other \_\_\_\_\_  
Breed: \_\_\_\_\_  
Color: \_\_\_\_\_  
Gender: Male / Female / Male Neutered / Female Spayed  
Ownership (Circle One): \_\_\_\_\_ Days / Months / Years  
Purchased (Circle One): Rescue / Breeder If Rescued, location? \_\_\_\_\_

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**All payments are due at the time of services rendered.**  
We accept cash, checks, and all major debit/credit cards.

I have read and understand the above statements and agree to all terms therein.

Signature of Owner: \_\_\_\_\_ Date: \_\_\_\_\_