

New Client Registration Form

WE NEED A COPY OF YOUR DRIVER'S LICENSE

ANIMAL CLINIC OF WEST PLAINS, INC.

1101 State Route 17, West Plains, MO 65775

Name _____ Spouse/Co-Owner _____
First Last First Last

Address _____
Street City State ZIP Code

Home Phone _____ Cell Phone _____ Emergency Contact # _____

Email Address _____ Emergency Contact Name _____

Social Security # _____ Drivers License # _____ Date of Birth _____

Owner's Employer _____ Work Phone _____

Spouse/Co-Owner's Employer _____ Work Phone _____

How did you hear of us? Yellow Pages Newspaper Sign Friend Website Other _____

Animal(s) we are seeing today:

Name _____

Dog Cat Horse Other _____

Inside Pet Outside Pet In/Outside Pet

Date of Birth/Age _____

Sex: Male Neutered Female Spayed

Gelding Stallion Mare

Breed _____ Color _____

Vaccination History (Date/Type of Most Recent Vaccines)

Date of Last Coggin's Test (Equine Only) _____

Would you like us to enter the above vaccinations in your pet's records so that you will receive a reminder when they are due again? Yes No

On-Going Health Problems _____

Current Medications (If Any) _____

Known Allergies or Reactions _____

Name _____

Dog Cat Horse Other _____

Inside Pet Outside Pet In/Outside Pet

Date of Birth/Age _____

Sex: Male Neutered Female Spayed

Gelding Stallion Mare

Breed _____ Color _____

Vaccination History (Date/Type of Most Recent Vaccines)

Date of Last Coggin's Test (Equine Only) _____

Would you like us to enter the above vaccinations in your pet's records so that you will receive a reminder when they are due again? Yes No

On-Going Health Problems _____

Current Medications (If Any) _____

Known Allergies or Reactions _____

I hereby authorize the veterinarian to examine, prescribe for or treat the above described pet(s). I assume responsibility for all charges incurred in the care of my pets. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment. As part of the consideration hereof, I agree to pay all costs of collection, including but not limited to all court costs and reasonable attorney's fees if this account is placed in the hands of an attorney for collection.

Method of Payment: Cash Check/Debit MC/VISA Discover American Express CareCredit

Owner/Agent Signature: _____ Date: _____