

NEW PATIENT REGISTRATION

Your Name _____ Spouse _____

Address _____

City _____ State _____ Zip Code _____

Driver's License # _____

Telephone Numbers (Please include area codes)

Home Phone _____ Cell Phone _____ Work Phone _____

Spouse's Cell Phone _____ Spouse's Work Phone _____

Occupation _____ Employer _____

Spouse's Occupation _____ Spouse's Employer _____

COMMUNICATION PREFERENCE

We now have the ability to communicate by email, text messaging, and voice messaging. Please list your preferences below.

Preference #1 Email / Text / Voice _____ (home / cell / work)

Preference #2 Email / Text / Voice _____ (home / cell / work)

Preference #3 Email / Text / Voice _____ (home / cell / work)

____ I would prefer **NOT** to receive **text** messages

____ I would prefer **NOT** to receive **emails**

Please Note: Your privacy is important to us.

All information received in all forms and through other communications is subject to our Patient Privacy Policy.

PET INFORMATION

1. Pet's Name _____ Dog Cat

Age/DOB _____ Breed _____ Color _____

Male Neutered Female Spayed

Prior Illness _____

Current Medications _____

2. Pet's Name _____ Dog Cat

Age/DOB _____ Breed _____ Color _____

Male Neutered Female Spayed

Prior Illness _____

Current Medications _____

All payments are due at the time of services rendered.

We accept cash, checks, all major credit cards, & Care Credit which can be approved in as little as 10 minutes.

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

Signature: _____ Date: _____