

HEALING HANDS ANIMAL HOSPITAL NEW CLIENT REGISTRATION FORM

Client Name: _____
Birth date: _____ Social Security #: _____
Spouse Name: _____ Birthdate: _____
Street Address: _____
City- St- Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Spouse Work/Cell: _____
Email address: _____
Employer: _____
Emergency Contact Name: _____ Phone: _____

How did you learn about us? (check all that apply):

- Sign
- Newspaper
- Other: (explain) _____
- Recommended by:
- Metropolitan
- Website

We offer a 10% discount for the following (please check any that apply to you or your spouse):

- Military
- Senior Citizen (birthdate: _____)
- Chamber of Commerce member

Pet's Name _____ Dog Cat Breed: _____
Color: _____ Markings: _____
 Male Neutered Female Spayed

Foods your pet eats: _____
Current Medications: _____
Prior surgeries/illnesses _____

Please check any symptoms or problems you've recently noticed with your pet:

- Appetite Loss
- Behavioral Changes
- Breathing Problems
- Coughing
- Depression
- Diarrhea
- Eye Disorders: _____
- Gagging
- Gums Bleeding
- Limping
- Loss of Balance
- Scooting
- Scratching
- Sneezing
- Thirst
- Urination Increase
- Vomiting
- Weakness
- Shaking Head
- Other: _____

Authorization

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the care of the animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment or hospitalization.

Signature of Owner: _____ Date: _____

Method of payment: Cash Check Credit Card