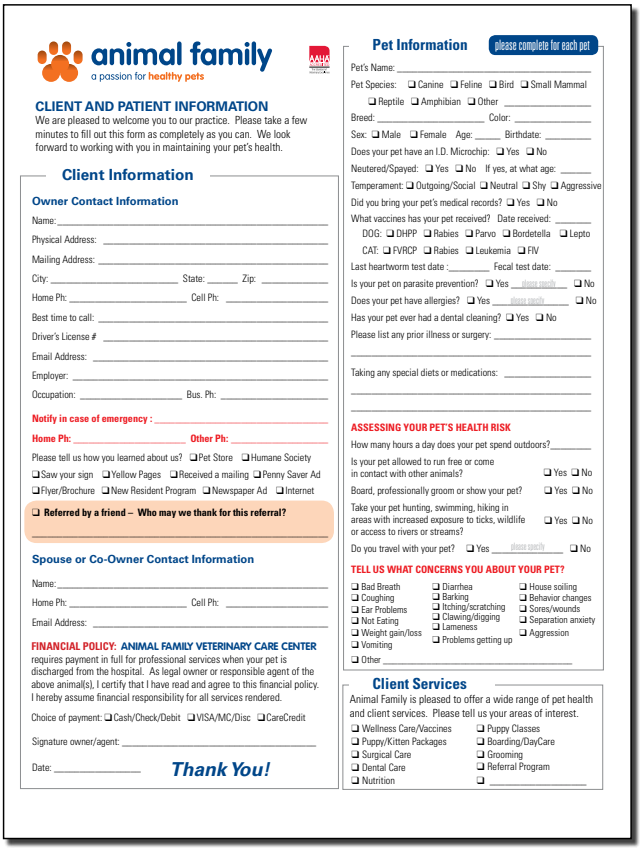
New Client and Patient Registration Form



animal family
a passion for healthy pets

CLIENT AND PATIENT INFORMATION
We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. We look forward to working with you in maintaining your pet's health.

Client Information

Owner Contact Information

Name:
Physical Address:
Mailing Address:
City: State: Zip:
Home Ph: Cell Ph:
Best time to call:
Driver's License #
Email Address:
Employer:
Occupation: Bus. Ph:

Notify in case of emergency :
Home Ph: **Other Ph:**

Please tell us how you learned about us? ❑Pet Store ❑Humane Society ❑Saw your sign ❑Yellow Pages ❑Received a mailing ❑Penny Saver Ad ❑Flyer/Brochure ❑New Resident Program ❑Newspaper Ad ❑Internet

❑ **Referred by a friend – Who may we thank for this referral?**

Spouse or Co-Owner Contact Information

Name:
Home Ph: Cell Ph:
Email Address:

FINANCIAL POLICY: ANIMAL FAMILY VETERINARY CARE CENTER requires payment in full for professional services when your pet is discharged from the hospital. As legal owner or responsible agent of the above animal(s), I certify that I have read and agree to this financial policy. I hereby assume financial responsibility for all services rendered.

Choice of payment: ❑Cash/Check/Debit ❑VISA/MC/Disc ❑CareCredit

Signature owner/agent:

Date: ***Thank You!***

Pet Information please complete for each pet

Pet's Name:
Pet Species: ❑ Canine ❑ Feline ❑ Bird ❑ Small Mammal ❑ Reptile ❑ Amphibian ❑ Other
Breed: Color:
Sex: ❑ Male ❑ Female Age: Birthdate:
Does your pet have an I.D. Microchip: ❑ Yes ❑ No
Neutered/Spayed: ❑ Yes ❑ No If yes, at what age:
Temperament: ❑ Outgoing/Social ❑ Neutral ❑ Shy ❑ Aggressive
Did you bring your pet's medical records? ❑ Yes ❑ No
What vaccines has your pet received? Date received:
DOG: ❑ DHPP ❑ Rabies ❑ Parvo ❑ Bordetella ❑ Lepto
CAT: ❑ FVRCP ❑ Rabies ❑ Leukemia ❑ FIV
Last heartworm test date : Fecal test date:
Is your pet on parasite prevention? ❑ Yes please specify ❑ No
Does your pet have allergies? ❑ Yes please specify ❑ No
Has your pet ever had a dental cleaning? ❑ Yes ❑ No
Please list any prior illness or surgery:
Taking any special diets or medications:

ASSESSING YOUR PET'S HEALTH RISK

How many hours a day does your pet spend outdoors?
Is your pet allowed to run free or come in contact with other animals? ❑ Yes ❑ No
Board, professionally groom or show your pet? ❑ Yes ❑ No
Take your pet hunting, swimming, hiking in areas with increased exposure to ticks, wildlife or access to rivers or streams? ❑ Yes ❑ No
Do you travel with your pet? ❑ Yes please specify ❑ No

TELL US WHAT CONCERNS YOU ABOUT YOUR PET?

❑ Bad Breath ❑ Coughing ❑ Ear Problems ❑ Not Eating ❑ Weight gain/loss ❑ Vomiting
❑ Diarrhea ❑ Barking ❑ Itching/scratching ❑ Clawing/digging ❑ Lameness ❑ Problems getting up
❑ House soiling ❑ Behavior changes ❑ Sores/wounds ❑ Separation anxiety ❑ Aggression
❑ Other

Client Services

Animal Family is pleased to offer a wide range of pet health and client services. Please tell us your areas of interest.

❑ Wellness Care/Vaccines ❑ Puppy/Kitten Packages ❑ Surgical Care ❑ Dental Care ❑ Nutrition
❑ Puppy Classes ❑ Boarding/DayCare ❑ Grooming ❑ Referral Program ❑ _____

BACKSIDE

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Breed: Color:
Sex: ❑ Male ❑ Female Age: Birthdate:
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3245 University Ave. #1-525
San Diego, CA 92104
ph. 800-803-8832
fax 888-302-8832

Order Form
fax to 888-302-8832

Custom-Design Fee $129

Design fee includes 2 revisions. (Each additional revision is $29)

❑ **ONE COLOR black ink, double-sided**
- ❑ Print 500 $179 + s/h
- ❑ Print 1,000 $239 + s/h

❑ **FULL COLOR, double-sided**
- ❑ Print 250 $198 + s/h
- ❑ Print 500 $379 + s/h
- ❑ Print 1,000 $559 + s/h

We custom design this client registration form to meet your unique practice requirements.

Comments/Requests

Practice Name:

Veterinarian:

Circle Credit Card Type: VISA MASTERCARD AMX DISCOV

C.C. #:

Exp. Date: CVC #

Address:

City:

State/Zip:

Phone #:

FAX #:

Contact Person:

Signature:

Include Practice Logo ❑ YES ❑ NO
Include AAHA Logo ❑ YES ❑ NO
Include Social Network Logo ❑ YES ❑ NO

circle your choices

IF YOU ARE INCLUDING YOUR HOSPITAL LOGO OR PHOTOS PLEASE E-MAIL THEM TO: phil@philwinter.com