Salt Creek Veterinary Hospital

*Thank you for giving us the opportunity to care for your pet! To ensure the best care possible, please take the time to fill in this form completely.*

# WELCOME

## CLIENT REGISTRATION

Last Name: _____First:_____Spouse:_____

Address: _____ City: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Spouse Cell: _____

Employer: _____ Phone # _____

Spouse Employer: _____ Phone # _____

Date of Birth_____ Driver's License #_____ SS #_____

Spouse DOB _____ Driver's License # _____ SS # _____

Email Address (For Future Reminders) _____

## PATIENT INFORMATION

| | Pet #1 | Pet #2 | Pet #3 |
|---|---|---|---|
| Pets Name | | | |
| Dog/Cat/Other | | | |
| DOB/Age | | | |
| Color | | | |
| Male/Female | | | |
| Spay/Neutered | | | |
| Breed | | | |

At what hospital was your pet last vaccinated or treated: _____

Any previous illnesses or surgeries? :_____

Any allergies to vaccinations or medications? :_____

Is your pet on any special diet or medications? :_____

## 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 this animal. I understand that these charges must be paid in full at the time of services and a deposit may be required for surgical treatment or emergencies.

Signature of Owner: _____ Date: _____

Method of Payment (Please Circle One)

☐ Cash ☐ Check ☐ MasterCard ☐ Visa ☐ Discover

**Checks will NOT be accepted without**
**Driver's License Number, DOB, Phone Number, and Physical Address**