

# New Client Registration

Thank you for giving us the opportunity to care for your pet. Please help us better meet your needs by taking a few moments to fill out this information sheet.

Owner's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_

Preferred Contact Number: Home  Work  Cell

Secondary Contact Information:

Name: \_\_\_\_\_

Primary Phone: \_\_\_\_\_

Secondary Phone: \_\_\_\_\_

How did you hear about us? (*whom may we thank*) \_\_\_\_\_

Our practice uses automated notifications for vaccine reminders, prescription pick-up, lab results notifications, and appointment reminders. Please select your desired notification preference.

All Notifications  Email  Text  Phone Calls

**If contacted, are we at liberty to discuss your pet's medical record with your groomer, boarder, another veterinary office, a family member or friend?**

Yes  No

*(Please note that if "no" is chosen we must be able to reach you each time information is requested. Please contact us immediately if you would like to change your status.)*

May we call your previous/current veterinarian for vaccine and medical history on your pet? Yes  No

Name of Previous/Current Veterinarian: \_\_\_\_\_

Phone number: \_\_\_\_\_ Location: \_\_\_\_\_

**FULL PAYMENT IS REQUIRED AT TIME OF SERVICES RENDERED.**

The following payment options are available: Cash, personal checks (*there is a \$35 charge for all returned checks*), all major credit cards, and Wells Fargo Health Advantage Program (*application submission and payment processing available in clinic*).

**A current and valid state or federally issued photo identification is required to be placed on file with this form. This identification will need to be updated as it expires.**

I hereby authorize Advanced Care Veterinary Hospital to receive, prescribe for, vaccinate, treat or perform surgery on the animals listed on the reverse side and any additional animals that I may present, as needed for the health and well-being of the animal(s). Furthermore, I agree to pay for services rendered at the time the pet is discharged from the hospital.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Patient Information

Client Name (Last, First): \_\_\_\_\_

General Information	Pet #1	Pet #2	Pet #3
Pet Name			
Species	Canine / Feline Exotic: _____	Canine / Feline Exotic: _____	Canine / Feline Exotic: _____
Breed			
Color			
Age or DOB			
Sex	M or F	M or F	M or F
Neutered or Spayed?	Y or N	Y or N	Y or N
Flea & Tick Prevention products used			
Heartworm Prevention used			
Daily Medications, Vitamins, or treats			
Known allergies, medication reactions, or chronic conditions			

**Please review the following statements:**

At Advanced Care Veterinary Hospital we enjoy sharing our patients' photos & stories within our hospital, our website & our social media platforms. Sharing photos and stories is a simple, effective, & fun way to assist us in educating other pet owners about their pets health. We would love your permission to share photos of your pet & their story.

- I hereby grant *Advanced Care Veterinary Hospital and its representatives* the right to photograph my pet and copy-right, use & publish said images. Publication includes both print and electronic publication, including, but not limited to, our website, our blog & our social media.
- I grant *Advanced Care Veterinary Hospital and its representatives* the right to copyright, use and publish my pet's story for any lawful purpose, including, but not limited to, social media content, blog content, digital and printed educational content.

**Please choose ONE option below:**

- I AGREE and give Advanced Care Veterinary Hospital the right to share images and/or stories of my pet(s).
- I DECLINE. Please do not share images and/or stories of my pet(s).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_