Animal Medical Hospital

Date:_____ Patient Account:_____

Patient Registration

Patient Information

Species: ☐ Canine (Dog) Pet's Name:_____Sex: ☐ Male ☐ Neutered

☐ Feline (Cat) Breed:_____ ☐ Female ☐ Spayed

☐ _____ Color:_____ Birthdate: _____

Owner Information

_____

Last Name First Name Initial Driver's License No.

_____

Mailing Address Cell Phone No.

_____

City State Zip Home Phone No.

_____

Employer(s) Name(s) Address City State Zip Work Phone No.

_____

Other Person Responsible ☐Spouse ☐Other Driver's License No.

_____

Address (if different from above) City State Zip Cell Phone No.

_____

Employer(s) Name(s) Address City State Zip Work Phone No.

I prefer to receive correspondence & reminders via ☐ Snail Mail ☐ E-mail _____

_____

Medical Reference Information

Have other pets you have owned been patients here? ☐ Yes ☐ No

_____

Previous Veterinary Doctor or Hospital Address City State Zip

Whom may we thank for the referral? _____

I acknowledge I am over 18 and I am the responsible party for this in terms of payment and liability.
I consent to the treatment of this animal by Animal Medical Hospital.

I prefer to make payment by: ☐Cash ☐Check ☐MasterCard ☐Visa ☐Discover

Signed_____