edgewater
ANIMAL HOSPITAL

NEW CLIENT PATIENT REGISTRATION FORM

We do not share, sell, or lend this information to any third parties other than required or as requested by the client.

Primary Contact: Ms Mrs Mr Dr **First Name**:_____**Last Name**:_____

Second Contact: Ms Mrs Mr Dr **First Name:**_____**Last Name**:_____

Address:_____Apt. #:_____

City:_____ State:_____ Zip Code:_____

Primary Contact Cell Phone #_____Home #_____

Work #_____Secondary Contact Name/Phone #_____

E-Mail Address (please print clearly):_____@_____
(We do not market any products by email. We may use email for doctor to client communication and to send reminders.)

Pet's Name:_____ (Circle) Dog Cat Other_____

Breed:_____ Sex (Circle): Male Male Neutered / Female Female Spayed

Date of Birth:____/____/_____ Or Estimated Age (Years or months):_____ Or Unknown___

Pet Color and Markings:_____

Does your pet have a microchip? YES NO Do you know the number?_____

(Estimated) Date of Last Veterinary Exam:_____ Pet's Diet:_____

Any Medical Condition/Medical History we should know?_____

Please list any Medication or Supplements your pet is taking:_____

How did you hear about us? Friend Name:_____Internet (please specify)_____

Neighborhood (please specify)_____Phonebook_____

Other (please specify)_____

Method of Payment: Credit Card (Amex, Visa, MC, Discover)_____ Cash_____

FINANCIAL POLICY SUMMARY: We do not accept checks. We do not bill for services.

Payment is due in full at the time services are performed. We are happy to provide estimates.