



CLIENT REGISTRATION Tech's Initials: _____

Client Information:

Name: _____ **How did you find out about us?**
Spouse / Co-Owner: _____ Drove by _____ Paper _____ Internet _____ Flyer _____
Address: _____ Personally Referred by: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Employer: _____
Spouse work number: _____ E-Mail: _____
Emergency Contact: _____ Phone: _____

Patient Information: (if more than 1, please include here or on the back)

Name: _____ Dog or Cat (Circle) Breed: _____
Date of Birth or Age: _____ Color: _____
Sex: (Circle one) Male/Neutered or Female/Spayed

Medical History Dog:

Rabies Date: _____ DHPP or DHLPP/C Date: _____
Bordetella Date: _____ Heartworm Test Date: _____
Fecal Test Date: _____ Microchip Number: _____

Medical History Cat:

Rabies Date: _____ FVRCP Date: _____
FELV Date: _____ FELV/FIV Test Date: _____
Fecal Test Date: _____ Microchip Number: _____

Diet: _____ Flea / Tick Control: _____
Heartworm Preventative: _____ Current Medications: _____
Previous Medical Problems Surgeries: _____

Please Note: PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED.

We accept Cash, Checks, Visa, MasterCard, Discover, and American Express.

I hereby authorize Winterfield Veterinary Hospital to provide services for my pet as required for maintaining proper health. I also understand that all fees are due and payable when services are rendered, and that I am responsible for any charges incurred due to returned checks or through collection efforts.

Signature: _____ **Date:** _____