Lacombe
Veterinary Hospital

CLIENT REGISTRATION

We thank you for the opportunity to provide veterinary care for your pet family member.
Please take a few moments to fill out this form as completely as possible.

CLIENT NAME: ***please print all entries***

θ Dr.
θ Mr.
θ Mrs.
θ Ms.

Mailing Address:

street

city state zip

Employer:

Spouse's/Co-owner's Name:

Spouse's/Co-owner's Employer:

All fees are due at the time services are rendered. You may pay by cash, credit card, or debit card. We also accept Care Credit. NO CHECKS ACCEPTED

E-mail (for email reminders and news):

What social media platforms do you use? (circle)
Facebook Twitter Pinterest Instagram
LinkedIn Google+ Other _____

Other Information our office should know:

CONTACT INFORMATION

Home Phone:

Work Phone (Self):

Work Phone (Spouse/Co-owner):

Cellular Phone (Self):

Cellular Phone (Spouse/Co-owner):

Pet Emergency Contact Name and Number: (you authorize us to speak to this person about your pet's care in the event we cannot reach you)

What is your preferred method of contact:

How did you hear about us?
Is there someone we may thank? (client referral)

_____

Circle One: Saw Our Hospital / Location
Google (or other search)
Yellow Pages (print)
Facebook
Online Review Site (Yelp, Angie's List etc.)
Other_____

FINANCIAL POLICY:

Our office accepts Visa, Mastercard, Discover, AMEX and Care Credit, along with cash. **Full payment is due at the time of service.** Clients with payment concerns are asked to speak to a Client Service Representative ***before*** their exam. Our staff is happy to provide any client with a written treatment plan prior to services being rendered. **Your signature below indicates your agreement with this policy.**

PHOTO CONSENT:

We love social media! Do we have your permission to share your pet(s)' image and story on social media, our website & other forms of related media? Simply check below to authorize this:
____Yes. I authorize LVH to share my pet's photo & story at any time.
____ No. I do not authorize this.

TREATMENT CONSENT:

I hereby authorize the veterinarian to examine, prescribe for or treat the below-described pet(s) to the best of their abilities. I assume responsibility for all charges incurred in the care of this animal. I acknowledge that medical information will not be released to anyone not indicated on this form without my express permission.

Owner Signature: _____ **Date:** _____

P E T # 1	**P E T # 2**
Pet's Name:	**Pet's Name:**
Date of Birth or Age:	**Date of Birth or Age:**
Species: ⋞ Dog ⋞ Cat ⋞ Other	**Species: ⋞ Dog ⋞ Cat ⋞ Other**
Breed:	**Breed:**
Sex: : Spayed/Neutered:	**Sex: : Spayed/Neutered:**
Color/Markings:	**Color/Markings:**
Vaccinations were last given by (clinic name): **Date:**	**Vaccinations were last given by (clinic name):** **Date:**
Allergies or Long-term Medical Problems:	**Allergies or Long-term Medical Problems:**
P E T # 3	**P E T # 4**
Pet's Name:	**Pet's Name:**
Date of Birth or Age:	**Date of Birth or Age:**
Species: ⋞ Dog ⋞ Cat ⋞ Other	**Species: ⋞ Dog ⋞ Cat ⋞ Other**
Breed:	**Breed:**
Sex: : Spayed/Neutered:	**Sex: Spayed/Neutered:**
Color/Markings:	**Color/Markings:**
Vaccinations were last given by (clinic name): **Date:**	**Vaccinations were last given by (clinic name):** **Date:**
Allergies or Long-term Medical Problems:	**Allergies or Long-term Medical Problems:**
P E T # 5	**P E T # 6**
Pet's Name:	**Pet's Name:**
Date of Birth or Age:	**Date of Birth or Age:**
Species: ⋞ Dog ⋞ Cat ⋞ Other	**Species: ⋞ Dog ⋞ Cat ⋞ Other**
Breed:	**Breed:**
Sex: : Spayed/Neutered:	**Sex: : Spayed/Neutered:**
Color/Markings:	**Color/Markings:**
Vaccinations were last given by (clinic name): **Date:**	**Vaccinations were last given by (clinic name):** **Date:**
Allergies or Long-term Medical Problems:	**Allergies or Long-term Medical Problems:**