ANIMAL WELLNESS CENTRE OF WESLEY CHAPEL

CLIENT REGISTRATION FORM

Thank you for giving us the opportunity to care for your pet. Please completely fill out the form below so we can provide the best possible care.

CLIENT INFORMATION

Owner's Name:_____ Address:_____

Phone #:_____ Home Cell Work Unit #:____ Zip:_____ City:_____ State:____

Emergency/Alt. Phone #:_____ Name & Relation to Owner:_____

Emergency/Alt. Phone #:_____ Name & Relation to Owner:_____

e-mail address:_____ Employer's Name & Phone #:_____

☐ Decline

PATIENT #1 INFORMATION

Name: _____ Sex: Male Female Spayed/Neutered: Yes No

Date of Birth/Age:_____ Species: Dog Cat Other:_____

Breed:_____ Color:_____ Microchip#:_____

Date of Last Teeth Cleaning:_____ Date of Last Vaccinations:_____

Previous Veterinarian(s) for Obtaining Records:_____

List Significant Medical History/Recurring Issues:_____

Current Medications:_____

Reason for Today's Visit:_____

PATIENT #2 INFORMATION

Name: _____ Sex: Male Female Spayed/Neutered: Yes No

Date of Birth/Age:_____ Species: Dog Cat Other:_____

Breed:_____ Color:_____ Microchip#:_____

Date of Last Teeth Cleaning:_____ Date of Last Vaccinations:_____

Previous Veterinarian(s) for Obtaining Records:_____

List Significant Medical History/Recurring Issues:_____

Current Medications:_____

Reason for Today's Visit:_____

How did you hear about us? Google Search Drive By Referral Other:_____

FINANCIAL INFORMATION

I hereby authorize Dr. Hong and the staff at Animal Wellness Centre to examine, prescribe for, and treat the above described pet(s). I release Dr. Hong and his staff from any liability related to any such care. Initial:_____

I authorize Animal Wellness Centre to use my pet's likeness for marketing purposes, including but not limited to use on their website or Facebook page. Initial:_____

I assume full responsibility for all charges incurred and I understand that a deposit may be required for hospitalization and/or treatment. I understand that ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED and agree to pay for services. Initial:_____

I understand that there is a minimum $25.00 service charge for all returned checks. Any unpaid accounts more than 30 days past due will be sent to a collection agency and are subject to a fee of at least 50% of the unpaid balance. Initial:_____

Signature:_____ Date:_____