Client Registration

Owner:	Co-Owner:			
Owner's Date of Birth:				
Secondary Phone:		_		
Address:				
Street	City	State	Zip Code	
Email:		Place of Employment:		
We value your personal information. Your email will only be notifications from Tenth Street Animal Hospital	e used for			
Additional Authorized Contact Name and Number	er:			
		You authorize us to speak to this person about your pet's care in the event that we cannot reach you.		
What social media platforms do you	use? Deacebo	· — —		
How did you hear about us?				
How did you hear about us? C Par	mily/Friend OV	vebsite C Google/Online C	Journal Media	
If you were referred by a client, please tell us when	no so we can say	thank you.	 	
1	New Patient Inf	ormation		
Pets Name		Pets Name		
Dog or Cat Breed:		Dog or Cat Breed:		
Sex: Male Female Neutered	Spayed	Sex: Male Female	Neutered Spayed	
Color: Birthday/Age:		Color: Birth	nday/Age:	
Previous Health Issues:		Previous Health Issues:		
		, , , , , , , , , , , , , , , , , , , ,		
Name and number of your pet's previous vetering	narian?			
We love social media! We would like your cons	sent to	O		
share your pets' image on our social media and		Yes, Please make my pet a	a star!!	
Your full name and personal information will nev used.	er be	☐No thank you my pet is shy		
Treatment Consent: I hereby authorize the vete	erinarian to eyam	ne prescribe for or treat the abo	ove described net(s) I	
assume responsibility for all charges incurred in		· · ·		
at the time of service. I recognize that financia				
convenience we accept Visa, Mastercard, Amer identification. Please stop at the reception desk	-		eck with proper	
I confirm that the above information is correct ar	nd that I am the o	wner or authorized agent of the p	patient(s) listed above.	
Signature:		Date:		