

# Clovercroft Veterinary Hospital Client and Pet Registration Form

**Pet Owner:** Name (Miss, Ms, Mrs., Mr., Dr.) \_\_\_\_\_

Spouse or other Authorized Agent Name \_\_\_\_\_

Address (& Apt #) \_\_\_\_\_

City, State, Zip \_\_\_\_\_ County: \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Work \_\_\_\_\_

Email Address(es) \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_

If someone recommended our hospital, please tell us so we may thank them. \_\_\_\_\_

If not referred, how did you select our hospital? (circle one) sign/location, internet, Facebook, other \_\_\_\_\_

Have you or any of your other animals ever registered with our hospital previously? (circle one) YES NO

**Pet Info:** Pet's Name \_\_\_\_\_

Breed \_\_\_\_\_ Color \_\_\_\_\_

Birth Date \_\_\_\_\_ Current Age \_\_\_\_\_

Sex (circle one) MALE FEMALE Spayed/Neutered (Fixed) (circle one) YES NO

Date of Last: Rabies Shot \_\_\_\_\_ Fecal \_\_\_\_\_ Heartworm Check \_\_\_\_\_

Canine: Distemper \_\_\_\_\_ Parvo \_\_\_\_\_ Kennel Cough \_\_\_\_\_

Feline: Distemper \_\_\_\_\_ Leukemia Test \_\_\_\_\_ Leukemia Vacc. \_\_\_\_\_

List other shots (Corona, Lyme, FIP, etc.) received and date given: \_\_\_\_\_

List current medications \_\_\_\_\_

List Special Diets \_\_\_\_\_ Type of Heartworm Preventive \_\_\_\_\_

Chronic Ailments, injuries, surgeries, known drug reactions, etc., \_\_\_\_\_

**Permission for Client/Patient Medical Record Release** \_\_\_\_\_YES \_\_\_\_\_NO

By checking YES you give Clovercroft Veterinary Hospital permission to freely share information (via phone, in writing, electronically, etc.) from your pet's medical record with anyone (groomer, boarding kennel, another vet's office, etc.) calling asking for medical information. Checking YES does not mean we will share your personal information such as your address, phone number or payment information.

## Payment Policy (Please read and sign)

**I understand payment is expected in full at the time services are provided. I willingly accept full financial responsibility for all procedures and treatments for pet above. I agree to make full payment for all services and products using either cash, check, Visa, MC, AmExpress, Discover.**

Signature \_\_\_\_\_ Date \_\_\_\_\_