MONTCLAIR VETERINARY HOSPITAL
CLIENT & PATIENT REGISTRATION

Please print clearly

YOUR NAME AND PARTICULARS:

Last ________________________________ First ____________________ Middle _______________

Address ______________________________________ City ______________ Zip _______________

Home Phone # ___________________ Work # ___________________ Cell # ____________________

Email address ____

Occupation ____

Alternate responsible adult (name) _____________________________ Phone # ___________________

Referred by ____

Previous Veterinarian ____

Family Members: # of adults _____________ # of children ______________ # of pets ______________

Name, Address & Phone Numbers of Owner, if not you, or of Parent if you are under 19:

____

PET:

Name _______________________________ Birthdate __________________ Age Today ___________

Breed ____ Color / Markings ______________________

Gender (sex) _____________________ ❒ Spayed ❒ Castrated Tattoo I.D. # ___________________

Who in your household has the primary relationship with this pet? ___________________________________

Your reason(s) for bringing your pet here today is (are): ____

____

If your pet has had any serious medical problems, allergies or drug reactions in the past, please list them by name with approximate dates: ____

____

When was your pet last vaccinated against: Canine DHLPP ____________ Canine Bordetella _____________

Canine / Feline Rabies ______________ Feline FRCP ______________ Feline Leukemia ______________

At what hospital(s) was your pet last vaccinated? ____

All fees are to be paid in full when services are performed. This policy helps control costs on which we base our fees. Please check your methods of payment: ❒ Cash ❒ Check ❒ Visa ❒ MasterCard ❒ ATM

I am financially responsible for the patient described above and agree to pay all fees incurred. I understand that any medical or surgical procedure is attended by some risk and that it is not possible to guarantee the successful outcome of any such procedure. This agreement is in force indefinitely from this date unless I notify the clinic in writing to the contrary.

Your Signature ____ Date _______________________

Please fax completed form to: 510-339-3215