# Client & Pet Registration

**Client Name**: ___________________________________________________________
Street Address: ___________________________________________________________
City: ________________________State: _____________________________Zip: ________
E-Mail Address: ___________________________________________________________
Home Phone: (____) _________________________________Cell Phone: _____________
Preferred Method of Contact: (Please circle one) Home / Cell / E-Mail / Text

**Pet Information:**
Name: _______________________ Male ☐ Neutered Male ☐ Female ☐ Spayed Female ☐
Age/Date of Birth: _____________ Species: Cat ☐ Dog ☐
Weight: ______________________

**Vaccination History:**
Distemper Date: ________________ Parvovirus Date: ________________ Rabies Vaccination: ________
Leptospirosis Date: ______________ FVRCP Date: ___________________

**Symptoms your pet is demonstrating**:

☐ Appetite Loss
☐ Behavior Changes
☐ Breathing Problems
☐ Coughing
☐ Depression
☐ Diarrhea
☐ Eye Disorders
☐ Gagging
☐ Gums Bleeding
☐ Limping
☐ Loss of Balance
☐ Scooting
☐ Scratching
☐ Shaking Head
☐ Sneezing
☐ Thirst
☐ Urination Increase
☐ Vomiting
☐ Weakness
☐ Other___________

**Comments:** ____________________________________________________________

**Payment Policy:** Our Office does not offer Billing. Payment is Due on the Day of Service. Our doctors will gladly prepare a written estimate during your appointment. In some instances, we require a deposit prior to treatment. We accept the following forms of payment: Cash, Credit/Debit card.
***Client Initials**: _______________________

**Treatment/Payment Authorization**: I understand every effort will be made to achieve a successful outcome and provisions will be made for safe in-hospital care and handling. I certify that I am 18 years of age or older and assume responsibility for all charges incurred. I understand that charges are due at the time services are rendered. I agree that should my account become delinquent, I will be responsible for all collection costs, including but not limited to the outstanding balance, interest, attorney fees, court costs, and collection agency fees.

I hereby authorize Willow Animal Hospital to treat my pet(s) and furthermore understand that unforeseeable adverse reactions to treatments are always possible and authorize treatment necessary should any reactions occur.

_____________________________________________ _____________________
***Signature of Owner or Authorized Caretaker:** **Date:**