



REGISTRATION FORM

New Client / Established Client Update

Please complete as much information as you can & print legibly.

Date: _____

| | | |
|--|---------------------------|------------------------------------|
| <u>Last Name:</u> | <u>First Name:</u> | <u>Title (Mr.,Mrs., Jr., etc):</u> |
| <u>Address:</u> | | |
| <u>City:</u> | <u>State:</u> | <u>Zip Code:</u> |
| <i>PLEASE <u>CIRCLE</u> THE PHONE NUMBER YOU PREFER TO BE CONTACTED AT:</i> | | |
| <u>Home Phone:</u> | <u>Work Phone:</u> | <u>Cell/Other:</u> |
| <u>E-Mail:</u> <input type="checkbox"/> <i>We send out email newsletters containing educational material & coupons, please check this box if you do not wish to be added to our newsletter list.</i> | <u>Spouse:</u> | |
| | <u>Spouse Cell Phone:</u> | |
| <u>Drivers License # & State of Issuance:</u> | <u>Spouse Work Phone:</u> | |
| <u>Employer:</u> | <u>I Was Referred By:</u> | |
| <u>Are you a previous client?</u> YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, how long ago? | | |
| ▶ ALL PROFESSIONAL FEES ARE TO BE PAID AT THE TIME SERVICES ARE RENDERED ◀ | | |

PET REGISTRATION INFORMATION

| | | |
|---|-----------------------|--|
| <u>Pet's Name:</u> | <u>Breed:</u> | <u>Circle One:</u> Long Medium Short Hair |
| <u>Color(s):</u> | <u>Age:</u> | <u>Sex:</u> MALE FEMALE |
| | <u>Date of Birth:</u> | <u>Spayed/Neutered:</u> YES <input type="checkbox"/> NO <input type="checkbox"/> |
| <u>My cat is (please circle one):</u> INDOOR OUTDOOR BOTH | | |
| <u>Is your pet...</u> | | |
| Declawed? YES <input type="checkbox"/> NO <input type="checkbox"/> Front <input type="radio"/> All four <input type="radio"/> | | |
| Microchipped? YES <input type="checkbox"/> NO <input type="checkbox"/> <i>We highly recommend microchipping. 😊</i> | | |
| Tested for feline leukemia (FeLV) or FIV ? YES <input type="checkbox"/> NO <input type="checkbox"/> Result of test? _____ | | |
| Has your pet received any of the following vaccines: FVRCP <input type="checkbox"/> FeLV <input type="checkbox"/> Rabies <input type="checkbox"/> FIP <input type="checkbox"/> | | |
| Date(s) of vaccines: _____ | | |
| Has your pet ever had a vaccine related reaction? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| Does your pet have any allergies? YES <input type="checkbox"/> NO <input type="checkbox"/> List allergies: _____ | | |
| Is there anything else we should know about your pet? (<i>Feel free to use the back of this form.</i>) _____ | | |
| _____ | | |

CLIENT SIGNATURE: _____