Chimacum Valley VETERINARY HOSPITAL

WELCOME TO OUR PRACTICE

Pet Townsend VETERINARY CLINIC

CLIENT REGISTRATION

We thank you for the opportunity to provide veterinary care for your pet family member.
Please take a few moments to fill out this form as completely as possible.

Client Name: *please print all entries*

Ms.

Mailing Address:

street

city state zip

Employer:

Spouse's/Co-owner's Name:

Spouse's/Co-owner's Employer:

All fees are due at the time services are rendered. If you wish to pay by check, credit card, bank or debit card, please complete the following:

Driver's License:

Exp Date:

E-mail (for email reminders and news):

What social media platforms do you use?

☐ Facebook ☐ Twitter ☐ Pinterest ☐ Instagram
☐ LinkedIn ☐ Google+ ☐ Other _____

Other Information our office should know:

CONTACT INFORMATION

Home Phone:

Work Phone (Self):

Work Phone (Spouse/Co-owner):

Cellular Phone (Self):

Cellular Phone (Spouse/Co-owner):

Pet Emergency Contact Name and Number: (you authorize us to speak to this person about your pet's care in the event we cannot reach you)

What is your preferred method of contact:

How did you hear about us?

Is there someone we may thank? (client referral)

_____

☐ Saw Our Hospital / Location ☐ Google (or other search)
☐ Yellow Pages (print) ☐ Facebook
☐ Online Review Site (Yelp, Angie's List etc.)
☐ Other _____

Facebook

FINANCIAL POLICY:

Our office accepts Visa, Mastercard, Discover and Care Credit, along with cash and checks (only with current DL information on file). **Full payment is due at the time of service.** Clients with payment concerns are asked to speak to a Client Service Representative ***before*** their exam. Our staff is happy to provide any client with a written treatment plan prior to services being rendered. Client will be responsible for a 1.5% monthly finance charge on accounts over 30 days and any collection fees on accounts over 90 days. As of September 1, 2015, we offer 6 months, no interest financing via Care Credit for clients in need a credit plan. No other payment plans are offered at this time. **Your signature below indicates your agreement with this policy.**

PHOTO CONSENT:

We love social media! Do we have your permission to share your pet(s)' image and story on social media, our website & other forms of related media? Simply check below to authorize this:
____Yes. I authorize CVVH/PTVC to share my pet's photo & story at any time.
____ No. I do not authorize this.

TREATMENT CONSENT:

I hereby authorize the veterinarian to examine, prescribe for or treat the below-described pet(s) to the best of their abilities. I assume responsibility for all charges incurred in the care of this animal. I acknowledge that medical information will not be released to anyone not indicated on this form without my express permission.

Owner Signature: _____ **Date:** _____

(Office Use Only) **Client ID:** _____ **Registered By** _____ **Welcome sent:** _____

PET # 1	PET # 2
Pet's Name:	**Pet's Name:**
Date of Birth or Age:	**Date of Birth or Age:**
Species: ☐ **Dog** ☐ **Cat** ☐ **Other** Dog	**Species:** ☐ **Dog** ☐ **Cat** ☐ **Other** Dog
Breed:	**Breed:**
Sex:	**Sex:**
Color / Markings:	**Color / Markings:**
Vaccinations were last given by (clinic name): **Date:**	**Vaccinations were last given by (clinic name):** **Date:**
Allergies or Long-term Medical Problems:	**Allergies or Long-term Medical Problems:**

PET # 3	PET # 4
Pet's Name:	**Pet's Name:**
Date of Birth or Age:	**Date of Birth or Age:**
Species: ☐ **Dog** ☐ **Cat** ☐ **Other** Dog	**Species:** ☐ **Dog** ☐ **Cat** ☐ **Other** Dog
Breed:	**Breed:**
Sex:	**Sex:**
Color / Markings:	**Color / Markings:**
Vaccinations were last given by (clinic name): **Date:**	**Vaccinations were last given by (clinic name):** **Date:**
Allergies or Long-term Medical Problems:	**Allergies or Long-term Medical Problems:**

PET # 5	PET # 6
Pet's Name:	**Pet's Name:**
Date of Birth or Age:	**Date of Birth or Age:**
Species: ☐ **Dog** ☐ **Cat** ☐ **Other** Dog	**Species:** ☐ **Dog** ☐ **Cat** ☐ **Other** Dog
Breed:	**Breed:**
Sex:	**Sex:**
Color / Markings:	**Color / Markings:**
Vaccinations were last given by (clinic name): **Date:**	**Vaccinations were last given by (clinic name):** **Date:**
Allergies or Long-term Medical Problems:	**Allergies or Long-term Medical Problems:**