

Barfield Animal Hospital

Client Registration Form

Last Name: _____ First Name: _____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

City: _____ State: _____ Zip Code: _____

E-Mail: _____ License # (Required): _____

Place of Employment: _____ Phone #: _____

Spouse/Co-Owner: _____

Place of Employment: _____ Phone #: _____

Pet's Name: _____ Gender: Male Female

Date of Birth or Estimated Age: _____ Neutered Spayed

Breed: _____ Color: _____

Date of Last Vaccinations: _____ Where: _____

Regular Vet: _____ Phone: _____

Is your animal: Indoor Only Indoor/Outdoor Outdoor Only

Rate your animal 0-10 (0=Timid--10=Aggressive) _____

Allergies: _____

Current Medications: _____

I hereby authorize the veterinarian to examine, prescribe, or treat the above described pet(s). I assume the responsibility for all charges incurred in the care of this animal. I understand that those charges will be paid at the time of release and that a deposit may be required.

Signature: _____ Date: _____

****Payments are due at time services are rendered.****

Please indicate your method of payment below:

Cash Check Care Credit Visa Mastercard Amex Discover

How did you hear of us? Yellow pages _____ Referral (if so, who) _____

Driving by _____ Other: _____