



Client/Patient Registration Form

OWNER INFORMATION:

Name: _____

Address: _____ City: _____ Zip: _____

E- Mail Address: _____

Home Tel #: _____ Cell #: _____

Employer: _____ Work #: _____

Spouse / Second Contact Name (circle one): _____ Phone #: _____

Has Kingston Animal Hospital, PC Veterinary Hospital ever treated any of your pets in the past?

YES

NO

How did you hear about our practice:

Proximity Doctors' Reputation

Credentials Yellow Pages

Friend's Recommendation (Name): _____

Other: _____

PATIENT INFORMATION:

Pet Name: _____

Species: Feline Canine Other _____

Breed: _____ Color: _____ Birthday: _____

Sex : Female Male Is your pet neutered / spayed? Yes No

Laboratory History: (approximate month/year)

Cats: FeLV test date: _____ FIV test date: _____

Dogs: Heartworm / Lyme test date: _____ Fecal exam date: _____

Vaccine Status: (month / year) **Where Given:** _____

Cats: Rabies date: _____ FVRCP date: _____ FeLV date: _____ FIV date: _____

Dogs: Rabies date: _____ DHL-Parvo date: _____ Lyme date: _____ Influenza date: _____

Medications your pet is currently taking: _____

Known Drug or Vaccine allergies: _____

Previous Medical or Surgical Problems: _____

Current Reason for office call: _____

METHOD OF PAYMENT: VISA MC AMEX DISC CHECK CASH

Signature: _____

Date: _____