REGISTRATION FORM

Date:_____________

Client information

Client Name: _____________ (first) _____________ (last) Co-owner/spouse:_____________ (first) _____________ (last)

Address: ____ street/po box city state zip

Home Phone: ______________________________ Work Phone: ______________________________

Cell phone (1): ______________________________ (name/number) Cell phone (2)______________________________ (name/number)

email:______________________________ Co-owner/spouse phone: ______________________

Referral information

Referring Doctor: ______________________ Referring Clinic:______________________________

Referred to:
❒ Cardiology ❒ Ultrasound/Imaging ❒ Oncology ❒ Internal Medicine
❒ Ophthalmology ❒ Behavior ❒ Surgery ❒ Physical Rehabilitation

(office use only: clinic phone number _________________________)

Pet information

Pet name: ________________ Species: ❒ Cat ❒ Dog ❒ Other Breed: ______________________

Color: ____________________ Age: __________ Birth date: __________

Sex: ❒ Female ❒ Male ❒ Spayed/Neutered Weight: ____________

Reason for visit: ____

Current medications: 1. ____________________________ 2. ____________________________

3. ____________________________ 4. ____________________________

Any previous medical problems: ____

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PATIENT AGREEMENT
I give permission to the staff of Peak Veterinary Referral Center to perform diagnostic, surgical and medical treatment as deemed advisable. It is understood that such procedures of diagnosis, surgery, and medical treatment will be discussed with me before proceeding except in emergency situations. In many cases, it is impossible to determine in advance the extent of surgical and/or medical treatment required, and I understand that the actual cost may be lower or higher than the estimate presented to me.

______________________________ ____________
Signature Date