



1 Hickman Veterinary Hospital

Today's date:	Preferred Veterinarian:
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CLIENT REGISTRATION FORM

Last name:	First:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Spouse's Name:
Mailing address:			Driver's License no.:	Home Phone Number: ()
City:	State:	Zip Code		Cell Phone: () Spouse's Cell ()
E mail:	Employer:			Employer phone no.: ()
Chose hospital because or Referred to hospital by:				

PATIENT INFORMATION

Pet's Name:	Species:	Breed:	Sex: Male Female Spayed or Neutered?
Age:	Color:	Reason for Visit:	Date of last vaccinations:
Does your pet have a microchip?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, microchip no.:
<i>Please indicate symptoms</i>		<input type="checkbox"/> Behavior Problems	<input type="checkbox"/> Breathing Problems
		<input type="checkbox"/> Coughing	<input type="checkbox"/> Diarrhea
		<input type="checkbox"/> Drinking More Water	
<input type="checkbox"/> Lack of appetite	<input type="checkbox"/> Limping	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Scooting
		<input type="checkbox"/> Scratching	<input type="checkbox"/> Seems Depressed
<input type="checkbox"/> Gagging	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Shaking Head	<input type="checkbox"/> Urinating More
		<input type="checkbox"/> Vomiting	<input type="checkbox"/> Weakness
<input type="checkbox"/> Other			
Please List any medications Your Pet is currently taking:			

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AUTHORIZATION AND PAYMENT

I hereby authorize the veterinarian to examine, treat, and prescribe for the above described pet(s), as deemed necessary and appropriate in the veterinarians professional judgment. **I assume responsibility for all charges incurred related to the care of this animal. I also understand that payment in full is due at the time that service is rendered or at the time that the patient is released into the owner's custody. We do not offer payment plans. A Deposit is required for hospitalized patients.**

We accept the following forms of payment: Visa / MC / AMEX Care Credit Check Cash

Please indicate your choice by checking the appropriate box above.

Client/ Owner/Responsible party signature	Date
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