Hickman Veterinary Hospital

Today's date:	Preferred Veterinarian:

CLIENT REGISTRATION FORM

Last name:	First:	❑ Mr. ❑ Mrs.	❑ Miss ❑ 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?	❑ Yes	❑ No	If yes, microchip no.:		
Please indicate symptoms	❑ Behavior Problems	❑ Breathing Problems	❑ Coughing	❑ Diarrhea	❑ Drinking More Water
❑ Lack of appetite	❑ Limping	❑ Loss of balance	❑ Scooting	❑ Scratching	❑Seems Depressed
❑ Gagging	❑ Sneezing	❑ Shaking Head	❑Urinating More	❑ Vomiting	❑ Weakness
❑ 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*

Veterinary Medical Records Release Form

In accordance with the Veterinary Practice Act regarding the confidentiality of patient medical records, a written authorization is required for Hickman Veterinary Hospital, Inc. to produce copies of your pet's medical records.

I, the undersigned, do hereby grant my permission for the release of any or all information contained in the medical record of All active or inactive pets in my client folder.

If you wish for Hickman Veterinary Hospital, Inc. NOT TO RELEASE RECORDS, please initial here. _____ Date_____

Client Signature _____Date_____

******This release will remain in effect until you notify us IN WRITING of any desired changes******