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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❑ Other

Please List any medications Your Pet is currently taking:

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/Discover ❑ Care Credit ❑ Check ❑ Cash

Please indicate your choice by checking the appropriate box above.

Client/ Owner/Responsible party signature | *Date*