WALNUT CREEK VETERINARY HOSPITAL

CLIENT REGISTRATION FORM

PRIMARY OWNER INFORMATION: (Please print clearly)

First Name: _____

Last Name: _____

Primary Owner DOB: (required for prescriptions) _____

Street Address: _____

City, State: _____ Zip: _____

Home Phone Number: _____

Cell Phone Number: _____

Work Phone Number: _____

Email Address: _____

SECONDARY OWNER/CONTACT INFORMATION:

First Name: _____

Last Name: _____

Relationship to primary: _____

Street Address: (if different from primary) _____

City, State: _____ Zip: _____

Home Phone Number: _____

Cell Phone Number: _____

Work Phone Number: _____

Email Address: _____

Would you like reminders emailed: Yes ☐ No ☐

Would you like reminders texted: Yes ☐ No ☐

Primary Phone Number: Home ☐ Cell ☐ Work ☐

Previous Veterinarian/Hospital: _____

Do we have permission to request records from the previous hospital: Yes ☐ No ☐

PET INFORMATION:

#1 Name: _____ Species (circle one): Canine / Feline Breed: _____

Sex: Male / Female Altered: Yes ☐ No ☐ DOB: _____ Color: _____

#2 Name: _____ Species (circle one): Canine / Feline Breed: _____

Sex: Male / Female Altered: Yes ☐ No ☐ DOB: _____ Color: _____

#3 Name: _____ Species (circle one): Canine / Feline Breed: _____

Sex: Male / Female Altered: Yes ☐ No ☐ DOB: _____ Color: _____

How did you hear about us: (select all that apply)

Facebook ☐ Instagram ☐ Yelp ☐ Google ☐ Website ☐ Other: (please specify) _____

Payment is required for all services when they are rendered unless prior arrangements have been made with hospital management. We accept cash, check, VISA or MASTERCARD and only take payments over the phone with prior approval. All returned checks are subject to a $35.00 service fee. Any account past due by 90 days is subject to collections and a $35.00 collection fee. Your signature below signifies your understanding and willingness to comply with hospital payment terms. In some cases, a deposit may be required before proceeding.

Veterinary Consent: I, the undersigned owner or owner's agent of the pet(s) identified, certify that I am over 18 years of age. I authorize Walnut Creek Veterinary Hospital to perform the treatment(s)/procedure(s) described in my pet's medical chart. I will be informed of the reasons for the treatment(s)/procedure(s), along with expected benefits and risks involved. I understand that unforeseen conditions may require an extension of planned treatment(s)/procedure(s). I hereby authorize the performance of such treatment(s)/procedure(s) as are necessary and advisable in the professional judgment of Dr. Jill Christofferson and or an Associate Veterinarian. I understand that I assume all risks and am responsible for all costs incurred.

_____ _____

SIGNATURE OF OWNER ***DATE***

540 Lennon Lane, Walnut Creek, CA 94598
(925) 448-2908