Client Registration Form

Client Information:

Date: _______________

Owner: ____

Address: ____

City ________________ State _______ Zip ____________

Primary Contact Number: _______________________ ☐ Home ☐ Cell ☐ Work

_______________________ ☐ Home ☐ Cell ☐ Work

Email Address: _______________________

Co-owner/Emergency Contact: ____

Co-owner Home Number: _______________ Cell: _____________ Work:__________

Pet Information:

Name of Pet: ____________________________ ☐ Canine ☐ Feline ☐ Other

Date of Birth: ___________________________ Breed:________________________

Color: ___________________________

☐ Male ☐ Female ☐ Neutered ☐ Spayed

Name of most Recent Veterinarian Seen: _________________________________

☐ I authorize the Back Bay Veterinary Clinic to obtain my pet's medical history from my previous veterinarian.

Please check off any of the following that you have noticed about your pet.

☐ Behavior Problems	☐ Gagging	☐ Shaking Head
☐ Bleeding gums	☐ Lack of appetite	☐ Sneezing
☐ Breathing problems	☐ Increased Thirst/Urination	☐ Limp
☐ Coughing	☐ Loss of balance	☐ Vomiting
☐ Diarrhea	☐ Scooting	☐ Weakness
☐ Ear Problems	☐ Scratching	☐ Other
☐ Eye Problems	☐ Not acting like self	_________________

Your Pet's Current Medication(s):____

____

Your Pet's Current Diet: ____

I hereby authorize the veterinarian and Back Bay Veterinary Clinic to examine, prescribe for, or treat the above described pet. I will assume responsibility for all charges incurred for the care of this animal. I also understand that these charges will be paid at completion of service or time of release and that a deposit may be required for surgical and/or in-hospital treatments.

Signature of Owner: ______________________________________Date: ________

How did you find out about our clinic? ☐ Internet ☐ Yellow Pages ☐ Referral ☐ Other ____________

Payment Options: American Express, Cash, Master Card and Visa only. Thank you.