COMMUNITY ANIMAL CLINIC

CLIENT REGISTRATION FORM

Last Name: _____ **First Name:** _____

Spouse/Other Name: _____ **E-mail Address:** _____

Address: _____ **City:** _____ **Zip Code:** _____

Referred by: _____

**** Please check next to the (primary) phone number we should contact first:***

[ ] Home Phone: _____ **[ ] Work Phone:** _____

[ ] Cell Phone: _____ **[ ] Spouse / Partner / Other Cell Phone:** _____

****Please have any records sent to us from your previous veterinarian prior to the appointment:**

E-mail : CommunityAnimal@cfl.rr.com **Fax : 386-446-4495**

Prior Veterinarian / City / State / Phone # : _____

Pet #1 Name _____ **Sex (circle): Male Female** **(circle): Intact Spayed Neutered**

Species (circle) Canine Feline **Breed**_____ **Color** _____

Birthdate: _____ **Age this Visit:** _____

Pet #2 Name _____ **Sex (circle): Male Female** **(circle) Intact Spayed Neutered**

Species (circle) Canine Feline **Breed**_____ **Color** _____

Birthdate: _____ **Age this Visit:** _____

Pet #3 Name _____ **Sex (circle): Male Female** **(circle) Intact Spayed Neutered**

Species (circle) Canine Feline **Breed**_____ **Color** _____

Birthdate: _____ **Age this Visit:** _____

Payment in full is due at the time of services rendered. I assume full responsibility for all charges incurred in the care of this pet(s). All returned checks are subject to a minimum $25.00 returned check fee. Outstanding balances past 30 days will accrue a minimum monthly $3.00 and a 1.5% finance charge.

Owner / Responsible Party Signature: _____ **Date:**_____