Registration Form

Date:______________

Client information

Client Name: ______________ ______________ Co-owner/spouse:________________ ______________
first last first last

Address: ____
street/po box city state zip

Home Phone: _________________________________Work Phone: ________________________________

Cell phone (1): _______________________________ Cell phone (2)_______________________________
name/number name/number

email:_______________________________________ Co-owner/spouse phone: ______________________

Referral information

Referring Doctor: ________________________ Referring Clinic:__________________________________

Referred to: ❒ Cardiology ❒ Ultrasound/Imaging ❒ Oncology ❒ Internal Medicine
❒ Ophthalmology ❒ Behavior ❒ Surgery ❒ Physical Rehabilitation

(office use only: clinic phone number __________________________)

Pet information

Pet name: _________________ Species: ❒ Cat ❒ Dog ❒ Other Breed: ______________________

Color: ____________________ Age: ___________ Birth date: ___________

Sex: ❒ Female ❒ Male ❒ Spayed/Neutered Weight: _____________

Reason for visit: ____

Current medications: 1. ______________________________ 2. ____________________________________
3. ______________________________ 4. ____________________________________

Any previous medical problems: ____

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PATIENT AGREEMENT
I give permission to the staff of Peak Veterinary Referral Center to perform diagnostic, surgical and medical treatment as deemed advisable. It is understood that such procedures of diagnosis, surgery, and medical treatment will be discussed with me before proceeding except in emergency situations. In many cases, it is impossible to determine in advance the extent of surgical and/or medical treatment required, and I understand that the actual cost may be lower or higher than the estimate presented to me.

____________________________________ _____________
Signature Date