

**Antioch Dog & Cat Hospital
Client Registration**

Please Print Clearly

Acct #

Name _____	
Address _____	
City/State/Zip _____	
Home # _____	E-mail address _____
Work # _____	Employer _____
Cell # _____	SS# (optional) _____
Driver's License # _____	Date of Birth _____

Spouse/Other _____	
Work # _____	Employer _____
Cell # _____	E-mail Address _____
Driver's License # _____	Date of Birth _____

How did you hear of us?
Yellow Pages <input type="checkbox"/>
Clinic Signs <input type="checkbox"/>
Internet/website <input type="checkbox"/>
Other <input type="checkbox"/>
Previous client <input type="checkbox"/>
Individual we may thank: _____

Payment is due upon the completion of services. We accept Cash, Check, Visa, MasterCard, & Discover
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<p>I assume responsibility for the charges incurred in the care of my pet(s). I also understand that these charges must be paid at the time of release and that a deposit may be required for the medical/surgical treatment.</p> <p>Signature: _____</p> <p>Date: _____</p>

Pet #1, Name _____ Date of Birth _____

Dog _____ Cat _____ Other _____

Male _____ Neutered _____

Female _____ Spayed _____

Declawed _____

Breed _____ Color _____

Date of last vaccinations (Mo/Yr) _____

Name of clinic where past records may be obtained? _____

Has your pet suffered from serious illness/injury in the past? Please explain. _____

Has your pet had an allergic reaction to vaccinations or medications in the past? Please explain. _____

Pet #2, Name _____ Date of Birth _____

Dog _____ Cat _____ Other _____

Male _____ Neutered _____

Female _____ Spayed _____

Declawed _____

Breed _____ Color _____

Date of last vaccinations (Mo/Yr) _____

Name of clinic where past records may be obtained? _____

Has your pet suffered from serious illness/injury in the past? Please explain. _____

Has your pet had an allergic reaction to vaccinations or medications in the past? Please explain. _____
