

Post Road Veterinary Hospital

New Client Registration Form

Date: _____

Pet's Name: _____ Date of Birth: _____

Canine _____ Feline _____ (indoor only / goes outside) Other _____

Breed: _____ Color: _____

Sex: Male _____ Neutered _____ Female _____ Spayed _____

My pet came from: _____

Owner's name: _____

Address: _____

Home phone: _____ Cell phone: _____

Preferred method of contact: home cell email

Spouse or significant other: _____ Spouse/relative phone: _____

Email address: _____

Your privacy is important to us. We do not sell, trade, share, or otherwise transfer your email address or other personal information to outside parties.

Medical History:

My pet is on the following medication(s) and dose(s):

1. _____
2. _____
3. _____
4. _____

My pet is on the following special diet: _____

Major medical issues, allergies, surgery:

1. _____
2. _____
3. _____
4. _____

Previous Veterinarian: _____

How did you find us? _____

Payment is expected as services are rendered. We accept cash, debit cards, Mastercard, Visa, Discover, and CareCredit.

Owner's Signature _____