

**SOCIAL CIRCLE VETERINARY HOSPITAL
NEW CLIENT REGISTRATION FORM**

PAYMENT IS DUE WHEN SERVICES ARE RENDERED, BILLING IS NOT AVAILABLE

Owner's Name (Last Name First) _____

Home Phone: _____ Cell Phone: _____

How would you prefer we contact you? Home Cell Is it ok to text you? Yes No

Spouse/Other (Last Name First) _____

Phone Number: _____ Is this a cell? Yes No

Physical Address: _____

City _____ State _____ Zip _____

Mailing Address (Same as above) _____

City _____ State _____ Zip _____

Email Address: _____

May we contact you by email? Yes No

Driver's License # _____ State _____ Exp _____

Date of Birth: _____ Social Security # _____

Occupation/Employer: _____

Work Phone: _____ May we contact you at work? Yes No

Whom may we thank for referring you? _____

I hereby authorize the veterinarian to examine, prescribe for, vaccinate and/or treat my pet(s). I understand that my animal must be current with all vaccines required by this facility to be seen. I assume all responsibility for all charges incurred in the treatment and care of my pet and understand that the charges are to be paid at the time of release of patient. I also understand that a deposit may be required for any treatment.

Signature

Date