WELCOME

Client & Patient Registration Form

CLIENT INFORMATION:

Last name: _____ First name: _____

Client DOB (**DEA Required**): _____ Primary Phone #: _____

Address: _____ City:_____ Zip:_____

Spouse / Partner: _____

Spouse/Partner #: _____ circle one: home / cell / work

Primary Email:_____

Employer / Occupation: _____

Referred by: _____

Primary Veterinarian: _____ Hospital: _____

PATIENT INFORMATION:

Name: _____ Breed: _____ ☐ CANINE ☐ FELINE

Color(s): _____ DOB/Age: _____

Sex (please circle): MALE / FEMALE ● Spayed or Neutered: YES / NO

Any food allergies? If so, please list: _____

Any serious medical problems or known drug reactions? _____

_____

Is your pet currently taking any medications? YES / NO **If so, please list Rx name, dose, & last given:*

Rx #1: _____ Rx #2: _____

Rx #3: _____ Rx #4: _____

Reason(s) for your visit today:_____

☐ My pet has health insurance; *Company:* _____ *Policy # (if available):*_____

☐ *Please check if you do NOT permit VetSurg to photograph your pet and use them for marketing purposes*

I hereby authorize the veterinarian to examine, prescribe for, and/or treat the above-described pet. I agree to have my pet's appointment audio recorded via a medical AI scribe system for medical record purposes. I assume full responsibility for all charges incurred for the care of this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment.

Signature: _____ Date:_____