Animalis Veterinary Clinic LLC

Veterinary House Call Services

CLIENT REGISTRATION FORM

(Please print legibly)

CLIENT INFORMATION

Last Name: | First: | Middle Initial:

How would you like to be addressed: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Prof ☐ Dr

Address:

City : | County: | State: | Zip Code:

Home Phone: | Cell Phone: | Work Phone:

E-mail Address:

Best Way to reach You: | Best Time to reach You:

Driver's License #: | State: | Date of Birth:

Other ID:

How would you prefer to be contacted: ☐ E-mail ☐ Text Message ☐ Phone Call ☐ Mail

EMERGENCY CONTACTS[1]

Last Name: | First name:

Home Phone: | Cell Phone: | Work Phone:

E-mail Address:

Relationship:

Last Name: | First Name:

Home Phone: | Cell Phone: | Work Phone:

E-mail Address:

Relationship:

WORK INFORMATION

Employer: | Occupation:

Employer Address:

City: | State: | Zip Code:

[1] Provide the name of 1 or 2 contacts (Over the age of 18) who can give consent regarding your Pet(s)

VETERINARY CARE

Name of previous Veterinary Practice:

Name of Pet's regular Veterinarian:

Phone: | Fax: | Website:

E-mail:

Animal Shelter or Pet Rescue Group:

Contact Person:

Address:

Phone: | Fax: | Website:

E-mail:

Other Veterinary Care (Please specify):

PET(S) RECORDS

☐ YES ☐ NO I authorize ANIMALIS Veterinary Clinic LLC to obtain all medical records regarding my Pet(s) from any Veterinary Office, Clinic or Hospital where my Pet(s) has been previously examined or treated.

☐ YES ☐ NO I authorize the release of my Pet(s) Medical Records if requested by another Veterinarian or Veterinary Practice.

☐ YES ☐ NO I authorize the release of my Pet(s) Medical Records should my Pet(s) be re-homed to a New Owner or Guardian.

PHOTO RELEASE

☐ YES ☐ NO I grant the right to Animalis, its representatives and employees to take and/or use photographs of me and/or my Pet(s) and to publish the same in print and/or electronically, such as publicity, illustration, advertising, web content and social media strictly for use related to Animalis Veterinary Clinic LLC.

ADDITIONAL INFORMATION (Optional)

The following questions are important in order to provide you and your Pet(s) the best care possible.

How many people ( ) Senior(s) ( ) Adult(s) ( ) Teenager(s) ( ) Children in the household?

Are there immune compromised individuals? ☐ YES ☐ NO

Client Recommendations:

Are there smokers? ☐ NO ☐ YES ☐ Indoor ☐ Outdoor

Is there anyone with Disabilities? ☐ YES ☐ NO

Client Recommendations:

Do you or anyone in your household have allergies? (Certain types of Animals/Medications/Chemical products)

Please, specify:

How many Pets?

HOW DID YOU LEARN ABOUT US

☐ Personal Referral (Whom may we thank?):

☐ Veterinary Practice Referral:

☐ Rescue/Shelter Organization :

☐ Car Magnet ☐ Flyer ☐ Direct Mailer ☐ Door Hanger

☐ Website ☐ Internet Search ☐ Social Media ☐ Newspaper

METHOD OF PAYMENT

Please indicate your preferred method of payment:

☐ Cash ☐ Check ☐ Debit Card ☐ Credit Card ☐ Care Credit

☐ I understand that PAYMENT is required the day services are rendered.