



Account # \_\_\_\_\_

# New Client Registration Form

Thank you for giving us the opportunity to care for your pet. Please take the time to fill out this form completely.

\* Note: The spouse/additional owner will have the rights to authorize medical care and changes to the account.

Owner's Name: \_\_\_\_\_

\* Name of Spouse/Additional Owner: \_\_\_\_\_

Street Address: \_\_\_\_\_

Spouse Phone: \_\_\_\_\_

\_\_\_\_\_

Spouse Email: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Address if different from Owners: \_\_\_\_\_

Driver's License #: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_

### How did you find out about our practice?

(Check any that apply. If you were referred by a current client, tell us so we can thank them!)

- Referred by: \_\_\_\_\_
- Drove By  Google/Internet Search
- Facebook  Yelp
- Phone Book  Angie's List
- Visited our website  Other: \_\_\_\_\_

### Which social media platforms do you use?

(Check any that apply.)

- Facebook  Twitter  Pinterest
- LinkedIn  Instagram
- YouTube  Snapchat

Pet's Name: \_\_\_\_\_ Species: Dog Cat Other: \_\_\_\_\_

Breed: \_\_\_\_\_ Color/Special Markings: \_\_\_\_\_

Date of Birth or Approximate Age: \_\_\_\_\_ Sex: M / F Spayed or Neutered?  Yes  No  Unsure

Previous animal hospital, if any: \_\_\_\_\_

Do you have pet insurance?  Yes  No If yes list provider: \_\_\_\_\_

1) **Photo Consent:** We love staying connected with our patients on social media! Do we have your permission to share your pet(s)' image and story on social media, our website, our blog, and other forms of related media? Your name and personal information will never be shared. Simply check below to authorize this:

- Yes. I authorize CHAH to share my pet's photo & story.
- No. I do not authorize this.

2) **Treatment Consent:** I hereby authorize the veterinarian(s) of Caring Hands Animal Hospital to examine, prescribe for, and/or treat the above described pet(s). I assume responsibility for the charges incurred for the care provided. I also understand that payment is due in full at the time of service. Deposits may be required in some instances. For services requiring hospitalization, including boarding, fees are to be paid in full at discharge. In the event of a returned check or non-payment, I agree to be responsible for the \$35 collection fee, as well as a 1.5% service fee that will be added to the account in addition to the entire amount due.

Signature of Owner/Agent: \_\_\_\_\_ Date: \_\_\_\_\_

Must be 18 years or older to sign.