TRINITY PET CLINIC CLIENT REGISTRATION

PLEASE PRINT

Date: ___________
Acct.#: ___________

CLIENT INFORMATION: *REQUIRED INFORMATION

Owner:
*Name ___________________________________
*Cell Phone: (____) ______________________
*Home Phone: (____) ______________________
*Email Address: ___________________________

Spouse, Co-Owner or Agent:
*Name: ___________________________________
*Cell Phone:(___) __________________________

*MAILING Address: ____
*City: ______________________________ *State: ______________ *Zip: ______________
Street Address (if different): ______________________________ **City:** ____________ **State:** _____ **Zip:** __________

PET INFORMATION:

1. Name: ________________	2. Name: ________________	3. Name: ________________
Microchipped? Yes______ No______	Microchipped? Yes______ No______	Microchipped? Yes______ No______
Dog _______ Cat_______ Other____________________	Dog _______ Cat_______ Other____________________	Dog _______ Cat_______ Other____________________
Breed____________________ Color_________________	Breed____________________ Color_________________	Breed____________________ Color_________________
Age________ Date of Birth__________	Age________ Date of Birth__________	Age________ Date of Birth__________
Sex: Male_______ Female_______ Spayed/Neutered? Yes____ No____	Sex: Male_______ Female_______ Spayed/Neutered? Yes____ No____	Sex: Male_______ Female_______ Spayed/Neutered? Yes____ No____
Date of Last Vaccinations:	Date of Last Vaccinations:	Date of Last Vaccinations:

Reason(s) for this visit (problems):
____

Pre-Existing Conditions (if any):
1. **Pet:** ______________________ Condition(s): ____
2. **Pet:** ______________________ Condition(s): ____
3. **Pet:** ______________________ Condition(s): ____

> Is your pet (#1, #2, and/or #3) currently receiving any medication (heartworm preventative, allergy medication, etc.)?
No ___ or Yes___ If yes, what? ____

> Does your pet have any known drug allergies? No___ or Yes __
If yes, what? ____

Referred By: ____

***ALL FEES MUST BE PAID AT TIME OF SERVICE.**

In the case of an emergency and/or hospitalization, a deposit may be required.
Upon request, we will provide you with a written estimate of fees before care is provided.

***Signature:** ____ Please circle one: **Owner** or **Agent**