SALMON FALLS ANIMAL HOSPITAL

CLIENT / PATIENT REGISTRATION

Owner's Last Name: _____ First Name: _____

Street Address: _____ Zip Code: _____ Home Phone: (____) _____

City: _____ State: ____ Work #: (____) _____ Cell# (____) _____

Email Address: _____ Dr Lic#: _____

Spouse/Relative Name: _____ Spouse/Relative Phone Number:_____

How did you first hear of us: Internet: ____, Friend: ____, Sign/Walk-in: ____, Other: _____

Pet's Name: _____ Species: _____

Breed: _____ Color: _____

Age/DOB: _____ Sex: _____ Spayed/Neutered? **Y or N**

Previous care where past records could be obtained: _____

I ASSUME RESPONSIBILITY FOR ALL CHARGES INCURRED IN THE CARE OF THIS ANIMAL. I UNDERSTAND THAT THESE CHARGES WILL BE PAID AT THE TIME OF RELEASE AND THAT A FINANCE CHARGE OF 1.5% IS ADDED TO ALL UNPAID BALANCES, AS WELL AS REASONABLE ATTORNEY OR COLLECTION FEES. A DEPOSIT MAY BE REQUIRED FOR SURGICAL TREATMENT. MASTERCARD/VISA IS AVAILABLE FOR YOUR CONVENIENCE.

Owner or Responsible Party: _____

PHOTO RELEASE

[ ] Yes [ ] No

We love social Media here at Salmon Falls Animal Clinic! Do we have your permission to share your pet's image and story on our Facebook, website, and other forms of social media? Your name and personal information will never be shared.