Glove Cities Veterinary Hospital

"making a difference, one paw at a time"

Client Registration Form

Please check one: ☐ New client ☐ Current client

Name: _____
Last First Middle Initial Spouse

Co-Owner's Name (if any) : _____

Address: _____ Physical Address: _____
Street City, State, Zip Street City, State, Zip

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Email Address: _____ Best number to contact you on: _____ Spouses Phone #_____

Place of Employment: _____ Spouse's Place of Employment: _____

Emergency Contact: _____ Phone:_____

How did you hear about us? (check one)

☐ Website ☐ Phone Book ☐ TV Commercial ☐ Friend/Family, who can we thank? _____

☐ Radio ☐ Local Channel 18 ☐ Other (please specify) _____

Patient Information

Name: _____ Birth Date/ Years Old: _____

Species: (check one) ☐ Ca ☐ Dog ☐ Other: _____

Breed: _____ Sex: ☐ Male ☐ Female

Color: _____ Spayed/Neutered? ☐ Yes ☐ No

Where was your pet last examined? _____ When? _____

Can we contact this hospital for your pet's medical history? _____

Is your pet on heartworm preventative? _____

Any long term medical problems? _____

Current Medications: _____

*Do we have permission to use a picture of your pet on our social media? (check one) ☐ Yes ☐ No

I understand that payment is due at the time of service and that I can pay by cash, check, MasterCard, Visa, Discover Card or Care Credit. I hereby authorize the doctor to examine, prescribe for, and treat the above pet.

Signature: _____ Date: _____