Owner and Patient Registration

Thank you for giving us the opportunity to care for your pet. Please print and complete all information.

Owner's Name: Title First Initial Last How would you like to be addressed?

Co-Owner's Name: Title First Initial Last How would you like to be addressed?

Names and ages of children living at home

Who is responsible for this account?

Address City State Zip

Home Phone Work Phone Cell Phone Permission to be texted Yes/No_____

Employer Occupation E-mail Address

Indicate method of payment: Cash__ Check__ Pet Health Insurance __ Credit Card (Name of credit card)_____

Driver's License No. State Credit Card No.

Owner's Social Security Number Birth date

How did you learn of our clinic (please be specific, and if applicable include the name of the person who referred you)?

I give permission for our pictures to be on the clinic website (www.bennettroadvet.com) and Facebook page:
Yes___ No___

ALL FEES ARE DUE AT THE TIME THE PATIENT IS RELEASED. PER YOUR REQUEST, WE WILL PROVIDE YOU WITH A WRITTEN ESTIMATE OF FEES FOR ANY TREATMENT, EMERGENCY CARE, SURGERY, OR HOSPITALIZATION. A DEPOSIT PRIOR TO TREATMENT MAY BE REQUIRED. THERE WILL BE A CHARGE OF $42.00 FOR ANY CHECK RETURNED. ANY BALANCE OVER 30 DAYS WILL ACRUE A SERVICE FEE OF 1.5%.

Owner's/Co-Owner's Signature Today's Date

PET INFORMATION:

_____

Pet's Name Male/Female Age Birth date

_____

Cat/Dog/Other Breed Color Has pet been Spayed/Castrated?

Does your pet have a Microchip? Yes____ No____ Microchip Identification #_____

Are there other pets in your household? Yes____ No _____ If yes, please indicate quantity below:

Dogs____ Cats____ Birds____ Reptiles____ Ferrets____ Other (Please specify)_____

NUTRITION:
Dry Food Brand_____ Canned Food Brand_____ Table Scraps? Yes____ No____
Any Holistic Therapies? _____

DENTAL CARE:
What dental care do you provide at home? _____ Date of last dental cleaning_____

HEARTWORM PREVENTIVE:
Is your pet currently taking heartworm preventive? Yes____ No____ If yes, Brand_____

MEDICAL RECORDS
Previous Doctor's or Hospital's Name_____

_____

What was last kind of treatment (exam, vaccs, etc)?

_____

Medical Conditions: Allergies, drug reactions, heart conditions, etc.

May we request that your pet's health records be transferred? Yes____ No____

VACCINATION and WORMING HISTORY:
Please indicate the date (month/year) your pet received the following vaccinations

CANINE	FELINE	BOTH
Distemper/Parvo_____	Distemper/Respiratory_____	Rabies_____
Coronavirus_____	Leukemia_____	Bordetella_____
Lyme_____	FIV_____	Fecal Exam_____
Other_____	FIP_____	Worming_____

EXOTIC SPECIES VACCINATIONS OR WORMINGS: Please specify type and date_____

Please describe the reason for your visit with us today: