

Dodd Animal Hospital

NEW PATIENT REGISTRATION

Your Name _____ Date _____

Address _____ Active Military _____

City _____ State _____ Zip Code _____ Senior Citizen _____

Driver's License _____ Social Security _____

Home Phone _____ Cell Phone #1 _____

Work Phone _____ Alt. Phone _____ Spouse Name _____

*Email _____ Spouse's Phone # _____

How did you become aware of our clinic? Sign _____ Yellow Pages _____ Internet _____ Other _____

Previous Client _____ Friend/Previous Client's Name _____

Pet Insurance _____

We must have a copy of your driver's license to accept checks, credit card or for Senior discount, and Military ID for Military discount.

Please note: Your privacy is important to us. All information received in all forms is subject to our Patient Privacy Policy.

PET INFORMATION

	PET 1	PET 2	PET 3
NAME			
BREED			
AGE/Date Of Birth			
COLOR			
SEX/SPAY OR NEUTERED			
HEARTWORM PREVENTION			
PREVIOUS VETERINARIAN			

_____ I agree to allow Dodd Animal Hospital to take pictures of my pet(s).

All payments are due at the time of services rendered.

We accept cash, checks, Visa, MC, Discover & offer Care Credit which can be approved in as little as 10 minutes.

I have read and understand the above statements and agree to all terms therein.

I AGREE TO PAY FOR ALL SERVICES AT THE TIME THEY ARE RENDERED.

Signature: _____ Date: _____