



NEW PATIENT REGISTRATION

Your Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone #1 _____

Work Phone _____ Cell Phone #2 _____

Email _____

PET INFORMATION

Pet's Name _____ Age/DOB _____ Weight _____

Breed _____ Dog / Cat / Other _____ Male

Color _____ Microchip / Tattoo # _____ Male / Neutered

Female
 Female / Spayed

Is this pet on flea/heartworm preventative? If yes, which _____

Pet's Name _____ Age/DOB _____ Weight _____

Breed _____ Dog / Cat / Other _____ Male

Color _____ Microchip / Tattoo # _____ Male / Neutered

Female
 Female / Spayed

Is this pet on flea/heartworm preventative? If yes, which _____

Pet's Name _____ Age/DOB _____ Weight _____

Breed _____ Dog / Cat / Other _____ Male

Color _____ Microchip / Tattoo # _____ Male / Neutered

Female
 Female / Spayed

Is this pet on flea/heartworm preventative? If yes, which _____

Please sign the following Authorization For Treatment

I hereby authorize the staff of Scripps Ranch Veterinary Hospital to render any treatment that is deemed necessary to my pet(s) health while in custody of the hospital. I understand that in the event of any unusual or emergency circumstances, the staff will make every attempt to contact me or my designated representative before, if time permits, proceeding with treatment. I understand that I will be financially responsible for all emergency procedures including the Estimate of Charges provided to me in person or over the telephone. **I understand that professional fees are to be paid at the time services are rendered.**

Signature of Owner

Date