AMAR GLEN VETERINARY HOSPITAL
CLIENT REGISTRATION FORM

LAST NAME | FIRST NAME | MIDDLE NAME | SPOUSE'S NAME

ADDRESS: _____
STREET | CITY | ZIP

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMAIL: _____ ☐ ALLOW EMAIL NOTIFICATIONS / REMINDERS

REFERRED BY: ☐ INTERNET ☐ RELATIVE / FRIEND : _____ ☐ OTHER _____

PET NAME	CAT / DOG	PET NAME	CAT / DOG	PET NAME	CAT / DOG
BREED	SEX	BREED	SEX	BREED	SEX
COLOR		COLOR		COLOR	
AGE	SPAYED / NEUTERED	AGE	SPAYED / NEUTERED	AGE	SPAYED / NEUTERED
BIRTHDATE		BIRTHDATE		BIRTHDATE	
DATE OF LAST VACCINATION OR BOOSTER		DATE OF LAST VACCINATION OR BOOSTER		DATE OF LAST VACCINATION OR BOOSTER	
DATE OF LAST RABIES VACCINAITON		DATE OF LAST RABIES VACCINATION		DATE OF LAST RABIES VACCINATION	

SIGNATURE OF OWNER: _____

SIGNATURE OF PERSON PRESENTING THIS PET FOR TREATMENT IF OTHER THAN OWNER: _____

ADDRESS OF NON-OWNER:

_____

_____

PHONE #: _____

PROFESSIONAL FEES ARE TO BE PAID AT THE TIME THEY ARE RENDERED.

We accept all Major Credit Cards, Debit Cards, CareCredit and ScratchPay