

LILES ANIMAL CLINIC

Today's Date _____ Owner/Patient Registration Client ID # _____

We appreciate the opportunity to help you care for your pet. Please provide the following information 😊

1. Owner's Name _____
Last First Middle Initial

2. Spouse/Co-Owner's Name _____
Last First Middle Initial

3. **Mailing Address** _____

4. City/State/Zip _____

5. Cell # _____ Spouse/Co-owner Cell # _____

6. **Email Address:** _____

7. Pets: Name _____ 8. Date of Birth _____

Male ___ Female ___ Dog ___ Cat ___ Other (Specify) _____ Breed _____

Color/markings _____ Has pet been spayed/neutered Yes ___ No ___

**** Date of last vaccinations/Heartworm Meds/Previous Health Problems****

9. I consent to have photos of my pet posted on Facebook, Instagram and/or Blog:
___ Yes, I consent. ___ No, I do not.

10. Reason for visit _____

11. Previous veterinarian's name (optional) _____
May we request your pets health records from him/her? Yes ___ No ___

12. How did you learn of our Clinic? Recommendation _____ Yellow Pages _____
Hospital Signs _____ Internet _____ Other _____

13. If personal recommendation- name of person, so we may thank them

All fees are due at the time services are rendered. On 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 depending on the amount of the estimate.

14. **Indicate how account will be paid:** Cash _____ Credit/Debit Card _____ Check _____

If paying by check we need the following:
DOB/ _____ Drivers Lic. State _____ DL # _____

15. **Signature of Owner** _____