

# Client Registration Form

Please complete this form and  
return to office personnel



OWNER: \_\_\_\_\_  
(Last) (First) (Middle)

CO-OWNER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_  
(Home) (Work) (Cell or other)

E-Mail Address: \_\_\_\_\_  
(Used for our newsletter or vaccination reminders. We will not release to any other sources)

## Tell us how you heard about us? *please specify one*

- Welcome Letter       Referral:  
 Sign Out Front      ↳ Person's name: \_\_\_\_\_  
 Verona Yellow Pages     Other yellow pages  
 Verona Area Chamber of Commerce     Web Site       Angel's Wish  
 Other : \_\_\_\_\_

How long have you lived here?     0-6 months     6-12months     over a year

Pet Name:	Breed:	Sex:	Neutered/Spayed?	Birth date/Age:	Color:
_____	_____	M F	Yes No	_____	_____
_____	_____	M F	Yes No	_____	_____
_____	_____	M F	Yes No	_____	_____

I hereby authorize the veterinarians of Verona Veterinary Medical Service, S.C. to examine, prescribe for and treat my companion(s). I assume responsibility for all charges incurred in the care of my pet(s). I also understand that all charges will be paid at the time of service or release from care and that a deposit may be required for surgical treatment. **SIGNATURE OF OWNER (or agent):** \* \_\_\_\_\_

I authorize the future release of vaccination records of my pet(s) without a signed *Release of Medical Records* document.  Yes  No \_\_\_\_\_ (initial) {If you indicate yes, the vaccination information will be considered non-confidential. All other Verona Veterinary Medical Service, S.C. records are considered confidential and require a signed *Release of Medical Records* document (and a deposit in the case of X-rays) before we are able to release the radiographs or a duplicate copy of the medical documents.} All records remain the property of Verona Veterinary Medical Service, S.C.

Office Use Only  
Account # \_\_\_\_\_