Owner/Patient Registration Form

Visit Us at www.deserttailsanimalclinic.com

Return Form to reception@deserttailsanimalclinic.com

Date:			
Last Name:	First Name:		
Co-owner Last Name:	Co-owner First Name:		
Address:	City:	State:	Zip:
E-Mail Address:	Home Phone:	Cell Number:	
Emergency Phone:	How were you referred to us? Personal referral (Name)		

Pet's Name:		
Date of Birth:		
Canine: ☐	Feline: ☐	Exotic: ☐
Male: ☐ Female: ☐	Spayed/Neutered: Yes ☐ No ☐	
Breed:	Color/Markings:	
Date of Last Vaccines:		
Any Known Illness or Conditions:		
Please list any medications:		

- ***We are not staffed 24 hours a day.***
- ***After-hours care is available at the closest emergency clinic.***
- ***After-hours care is at the discretion of the veterinarian.***
- ***Federal Law prohibits the dispensing of certain medications without examination or prescription.***
- ***Some prescriptions may be available at your local pharmacy. Please ask for information at the front desk.***
- ***Payment is due at the time services are rendered***
- ***Your understanding is appreciated. Thank you.***

I have read and fully understand the above statements. I assume full responsibility for all charges incurred in the care of said animal(s). I also understand that payment will be made at time of release and that a deposit may be required prior to any treatment.

Signature of Owner or Responsible Party:

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