

**CLIENT REGISTRATION FORM**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Client ID: \_\_\_\_\_

**Primary Owner:** First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Numbers: Home: \_\_\_\_\_ Cellular: \_\_\_\_\_ Work: \_\_\_\_\_ Other: \_\_\_\_\_

**Spouse or Secondary Owner:** First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Phone numbers: \_\_\_\_\_ Cellular: \_\_\_\_\_ Work: \_\_\_\_\_ Other: \_\_\_\_\_

**How did you hear About us?** Yellow Pages Sign or Location Web Search Friend or Neighbor: Other:  
Book or Web

**How would you prefer to be contacted for:** (Please circle your choice)

*Vaccine Due Dates:* Mail E-mail

*Advising pet out of Surgery:* Call Text E-mail

*Day before appointment reminder:* Call Text

E-mail Address: \_\_\_\_\_

**PAYMENT IS DUE AT TIME OF SERVICE:** We accept Cash, American Express, Visa, Master Card, Discover, ATM and Care Credit.

**I/We understand and agree that in the event of default, to pay reasonable collection and/ or attorney fees.**

X \_\_\_\_\_  
SIGNATURE OF OWNER

OWNER'S BIRTHDAY: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Required by the CA Department of Justice  
for dispensing some medications