



Dr. Michael Sweet, DVM
Dr. Robert Wagner, DVM
Dr. Laurina LeBoldus, DVM

**CLIENT & PATIENT
REGISTRATION
FORM**

Please print clearly and fill out completely so we can keep our records current. Thank you.

Client Information:

Please Check One: New Client Current Client – New Pet

Owners Name: _____
LAST FIRST TITLE

Address: _____

City: _____ Province: _____ Postal Code: _____

Owners Phone #: _____ Owners Cell Phone #: _____

Owners E-mail Address: _____

(Please note: we will only use your e-mail address to send out vaccination reminders)

Co-Owner/Spouse Contact: _____
LAST FIRST TITLE

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone #: _____ Cell Phone #: _____

Alternate Contacts:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Pet Information:

Name: _____ Breed: _____

Birthday: _____ Color: _____ Sex: M MN F FS

Primary Clinic Name: _____ Doctor: _____

Does your pet have any major ongoing medical conditions we should know about? Please List.

Do your pets travel out of the area? Please List.

Insurance:

Do you have pet insurance: Yes No Company: _____

Policy Holder: _____ Policy Number: _____

(Please note: we will need to set up a master claim form with your signature to keep on file)

All professional fees are due at the time services are rendered. Please ask for an estimate prior to any extensive medical or surgical procedure – we will be happy to provide one. We accept Cash, Interact, VISA, and Mastercard. We **DO NOT** accept American Express or Personal Cheques.

Signature of Owner: _____ Date: _____