

# Welcome to NorthPointe Animal Hospital

Thank you for making us Your Neighborhood Veterinarian. We are happy to be your partners in the care of your pet's health. To help us get to know your pet, please fill out the following information:

## NEW CLIENT/PATIENT REGISTRATION FORM

Date \_\_\_\_\_

### Owner Information (Please print)

Your name \_\_\_\_\_ Driver's License # \_\_\_\_\_ Exp. \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phones: Home \_\_\_\_\_ Business \_\_\_\_\_, ext. \_\_\_\_\_ Cell \_\_\_\_\_  
e-Mail address \_\_\_\_\_ Would you like to receive pet reminders via this e-mail? Yes / No

### Who else is responsible for your pet?

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phones: Home \_\_\_\_\_ Business \_\_\_\_\_, ext. \_\_\_\_\_ Cell \_\_\_\_\_  
e-Mail address \_\_\_\_\_ Would you like to receive pet reminders via this e-mail? Yes / No

### How did you hear about NorthPointe?

Referred by CVMA    Hospital Sign    Yellow Pages: SBC Yellow Pages / Valley Yellow Pages (please circle one)  
 Internet    Recommended by \_\_\_\_\_  
 Other: \_\_\_\_\_

### Your Pet (please fill out separate form for each pet)

Name of pet \_\_\_\_\_  Dog    Cat    Other : \_\_\_\_\_  
Male / Female: Spayed/neutered/unaltered (please circle)   Birthdate: \_\_\_\_\_ Microchip I.D. # \_\_\_\_\_  
Breed: \_\_\_\_\_ Color / Markings \_\_\_\_\_  
Vaccination History (date & type of last vaccinations): \_\_\_\_\_

Any disease your pet has been diagnosed with: \_\_\_\_\_  
Current medications: \_\_\_\_\_  
Describe your pet's diet: \_\_\_\_\_

Reason for visit today: \_\_\_\_\_

Have you noticed any of the following symptoms:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Behavior problems        | <input type="checkbox"/> Gagging          | <input type="checkbox"/> Seems depressed                   |
| <input type="checkbox"/> Bleeding gums            | <input type="checkbox"/> Lack of appetite | <input type="checkbox"/> Shaking head                      |
| <input type="checkbox"/> Breathing problems       | <input type="checkbox"/> Limping          | <input type="checkbox"/> Sneezing                          |
| <input type="checkbox"/> Coughing                 | <input type="checkbox"/> Loss of balance  | <input type="checkbox"/> Thirst and/or urination increased |
| <input type="checkbox"/> Diarrhea                 | <input type="checkbox"/> Scooting         | <input type="checkbox"/> Vomiting                          |
| <input type="checkbox"/> Eye bulging or bloodshot | <input type="checkbox"/> Scratching       | <input type="checkbox"/> Weakness                          |

## AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, and treat the above-described pet. I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for treatment.

Signature of Owner: \_\_\_\_\_ Date: \_\_\_\_\_

### Professional fees are to be paid at time services are rendered.

Payment method:  Cash    Check    MasterCard    Visa    Other \_\_\_\_\_  
Pet insurance company \_\_\_\_\_

I want to sign up for Care Credit (cost of professional services will be automatically charged to my credit card):

Card # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  MasterCard    Visa    Debit    \_\_\_\_\_  
Name on card \_\_\_\_\_ Limit \$ \_\_\_\_\_  
Signature \_\_\_\_\_