REGISTRATION FORM 12/13

Compassion Veterinary Clinic 275 Boston Post Road East Marlborough, MA 01752 508-481-VETS(8387)
Dr. G. Patil and Associates

OWNER INFORMATION

Primary Owner: _____ _____
(Must be 18 years of age or older) (First Name) (Last Name)

Spouse/Co-owner: _____ _____
(First Name) (Last Name)

Street Address: _____ **Apt.** _____

City/Town: _____ **Zip.** _____

Are you 65 years or older? ◯ no ◯ yes

Have you brought other pets here? ◯ no ◯ yes

If no, how did you learn of our clinic?

◯ yellow pages ◯ internet ◯ sign ◯ recommendation: _____

Home Phone:
( ) _____ - _____

Work phone:
( ) _____ - _____

Cell Phone:
( ) _____ - _____

Other Phone:
( ) _____ - _____

E-mail:
_____

PET INFORMATION

Name: _____

Species: ◯ dog ◯ cat ◯ other: _____

Breed: _____

Color: _____ **Distinguishing Marks:** _____

Gender: ◯ male ◯ female

Is pet altered (neutered/spayed)? ◯ no ◯ yes

Birthdate (or best approximation of age): _____

Has pet been seen by other vets? ◯ no ◯ yes: _____

Does pet have any allergies? ◯ no ◯ yes: _____

Any physical problems? ◯ no ◯ yes: _____

Any behavioral problems? ◯ no ◯ yes: _____

Is pet on any medication? ◯ no ◯ yes: _____

Does your pet have a microchip? ◯ no ◯ yes: _____

Please describe pet's diet:

◯ **dry food brand:** _____ ◯ **wet food brand:** _____
◯ **other:** _____

If pet is a cat; his/her environment is or will be: ◯ strictly indoors ◯ indoors & outdoors

AUTHORIZATION

I, the owner or agent of the owner of this pet, hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the care of this animal, that the charges will be paid at the time of release from each visit and that a deposit may be required prior to treatment. I also understand that a quote for any services will be given on request .

Signature: _____ **Date:** _____

Method of payment: ◯ **cash** ◯ **credit/debit** ◯ **check (driver's license #:** _____ **)**