

Cascade Animal Medical Center

New Client Registration Form

Thank you for giving us the opportunity to care for your pet. So that we may better serve your needs, please complete the following form and bring it to the animal hospital at the time of your appointment.

Please Print

Date_____

Owner's Name_____

Spouse_____

Address_____

City_____

Zip_____

Home Phone_____ Work Phone_____

Spouse's Work Phone_____

Place of Employment_____

How did you hear about Cascade Animal Medical Center?

Pet's Name_____ Breed_____

Color_____

Dog_____ Cat_____ Other_____

Sex_____ Neutered_____ Spayed_____

Age (Birthdate if Known)_____

Previous Vaccinations:

Rabies (Date)_____

Yearly Boosters (Date)_____

Others (Date)_____

Significant Medical Information About Your Pet

Professional fees are to be paid at the time they are rendered. Please circle your preferred method of payment.

Cash

Check

Mastercard

Visa

Signature of owner or person presenting the pet
