DALE ANIMAL HOSPITAL CLIENT REGISTRATION

Please Tell Us About Yourself **EMAIL:**_____

Owner _____ Spouse or Co-Owner _____

Owner Must Be 18 Years of Age or Older

Address _____

City/State/Zip Code _____

Owner (* Required)	Home Phone*		Cell Phone	
	Employer*		Work Phone*	
	SSN*		Driver's License No.*	
Co-Owner (* Required)	Home Phone*		Cell Phone	
	Employer*		Work Phone*	
	SSN*		Driver's License No.*	

Where did you hear about the Dale Animal Hospital?

Yellow Pages Neighborhood Friend: _____ Other: _____

**** If you where referred to us by a current client please let us know, both of you will receive a $5.00 credit!! ****

Please Tell Us About Your Pets

Pet's Name _____ Birthdate _____ Age _____

Dog Cat Other: _____ Breed: _____ Color _____

Male Neutered Female Spayed Date of Last Vaccinations _____

Pet's Name _____ Birthdate _____ Age _____

Dog Cat Other: _____ Breed: _____ Color _____

Male Neutered Female Spayed Date of Last Vaccinations _____

Pet's Name _____ Birthdate _____ Age _____

Dog Cat Other: _____ Breed: _____ Color _____

Male Neutered Female Spayed Date of Last Vaccinations

I authorize the Dale Animal Hospital to examine, prescribe for or treat my pets(s).
I assume responsibility for all charges incurred in the care of this (these) animal(s).

Payment is due for examinations, surgeries, prescriptions and retail items as they are provided.
We accept cash, check, Visa, Mastercard, Discover, and Care Credit

Client Signature _____ ***Date*** _____