

**Central Veterinary Center
4275 County Line Road #24
Chalfont, Pennsylvania 18914**

Registration Form

Owners Name _____
Address _____
City, State, Zip _____
Home Phone # _____
Work Phone # _____
Place of Employment _____
Alternate Phone # (cell) _____
Email Address _____
Would you prefer reminders mailed or by email Mailed _____ Email _____
Driver's License # (for identification and writing checks) _____

Emergency Contact person (other than yourself) _____
Relationship _____
Phone # _____
Alternate Phone # _____

How did you hear about us? _____
Pet's Name _____
Dog/Cat/Other (specify) _____
Date of Birth _____
Breed _____
Color _____
Sex _____
Spayed or Neutered? Yes _____ No _____
Do you have any medical records (if so please give to receptionist) Yes/No

List any and all medical problems and concerns as well as reason for visit -

Is your pet currently on any medications? (if so please list name of drug, dosage, and frequency given -

I attest that I am the owner/owner's agent authorized to make all medical decisions for the care of the animal. 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 services are rendered and that a deposit may be required for all medical treatments, hospitalization, and surgical services. Furthermore, I understand that all medical records for this pet are owned solely by and considered property of the hospital, and therefore, cannot be released to any other party without my consent. I assume responsibility for all charges associated with copying, faxing, or distributing this pet's medical history.

Owner or Owner's Agent _____ Date _____