Frontier Village
VETERINARY CLINIC

CLIENT MEDICAL REGISTRATION FORM

MEDICAL RECORD - HOSPITAL USE ONLY	
CLIENT ID #	_____
EMAIL ENTERED	_____
REFERRAL RECORDED	_____
REMINDERS ENTERED	_____
SCANNED INTO CS	_____
WELCOME CARD	_____

Welcome to our medical family!
Thank you for giving us the opportunity to care for your furry family members.

So that we may become better acquainted, please complete the following:

DATE: _____

CLIENT INFORMATION

Full Name: _____ Spouse/Co-Owner's Name: _____

Phone Number: _____ Spouse/Co-Owner's Phone: _____

Email: _____ Additional Phone Number/s (work): _____

Address: _____ City: _____ State: _____ Zip: _____

Place of Employment: _____ Best Time to Reach You: _____

NAME OF ADDITONAL PERSON/S TO BE LISTED ON ACCOUNT:
(Family/Roommate/Etc.)

_____

_____

_____

HOW DID YOU HEAR ABOUT US?

_____
(Personal Referral, Facebook, Yelp, Google Search, Drive-By, etc.)
If a personal referral, please list their name so we can thank them!

TREATMENT AUTHORIZATION and INFORMATION/PHOTO RELEASE

I hereby authorize Frontier Village Veterinary Clinic (FVVC) to perform medical and initial diagnostic/surgical procedures on this animal as required for diagnosis and treatment. I understand that I can terminate treatment at any time by contacting the doctors and assistants.

FVVC and its staff are leaders and teachers in the veterinary medicine field, thus case information and/or photos may be used in teaching, forms of continuing education, FVVC's website and social media, veterinary literature, and the like. I authorize the release of case/patient information for such purposes.

In the event that I sell this animal to another owner, I authorize release of medical information to the new owner.

FINANCIAL POLICY

Payment is due as services are rendered.

PLEASE INDICATE PREFERRED FORM OF PAYMENT: CASH ☐ DEBIT ☐ CREDITCARD (VISA/MASTERCARD) ☐ CHECK ☐

For hospitalized/admitted cases, a deposit is required in advance. The balance is due upon discharge from the hospital. Payments can be made by cash, personal check (deposited electronically prior to patient discharge with proper identification), and accepted credit cards, including Care Credit. If payment arrangements are needed, the undersigned realizes that they must be agreed upon prior to admitting patients. In order to avoid misunderstandings, please let us know immediately if these terms are not satisfactory.

I have read and accept the preceding obligations.

OWNER(S) SIGNATURE: _____ DATE: _____

CLIENT MEDICAL REGISTRATION FORM

PATIENT INFORMATION

NAME OF PREVIOUS VETERINARY CARE: _____

LOCATION: _____ PHONE/EMAIL IF KNOWN: _____

MAY WE CONTACT FOR RECORDS: ☐ Yes ☐ No

	PET #1	PET #2	PET #3
NAME			
BREED			
DATE OF BIRTH			
COLOR			
SEX: SPAYED OR NEUTERED			
YOUR DOG'S VACCINATION HISTORY:			
RABIES			
DHLP PARVO CORONA			
BORDETELLA			
FECAL (STOOL SAMPLE)			
OTHER			
YOUR CAT'S VACCINATION HISTORY:			
RABIES			
FVRCP			
FELV			
FVRCP/FELV TEST			
FECAL (STOOL SAMPLE)			

OUR PET(S) IS: ☐ MEMBER OF OUR FAMILY ☐ CHILD'S PET ☐ BACKYARD PET

Any pr evious serious illnesses or surgeries? _____

Any allergies to vaccinations or medications? _____

Is your pet on any special diets or medications? _____

Would you like to be present during treatment to your pet? ☐ Yes ☐ No

Any additional alerts or details to the care of your pets that you would like to make us aware of or request:

_____