ID#_____
Office Use Only

TRI-CITY VETERINARY CLINIC
1929 W. Vista Way
Vista, CA 92083
(760) 758-2091

Client/Patient Registration Form

Patient Information: **(PLEASE PRINT LEGIBLY)** Today's Date: _____

Pet's Name: _____Breed: _____ Color: _____

Birth date (or approx age): _____ Sex**:** _____ Altered?____ What food (type and brand) do you feed your pet? _____

Is your pet currently on any medication? Yes ☑ No ☐ If Yes, list: _____

List any medication or vaccine allergies or reactions: _____
(Write "NONE" if none are known)

Does your pet have a microchip? ____#_____ Your pet lives: ☑ indoors ☐ outdoors ☐ both indoor/outdoor

Is your pet currently under treatment by another veterinarian?_____If so, by whom?_____

Vaccination history:

Dog: DHLP/Parvo/Corona_____Bordetella_____ Rabies_____ Deworming_____
(date) (date) (date) (date) (date)

Last Heartworm test?_____ On Heartworm preventative medication?_____ Last fecal test and result? _____

Cat: FVRCP-P_____Leukemia_____FIP_____Rabies_____ Deworming_____
(date) (date) (date) (date) (date)

Last Feline Leukemia and/or FIV test and results?_____Last fecal test and result? _____

Client Information: **(PLEASE PRINT LEGIBLY)** **If the pet's owner is not present, please complete this form with your information and enter the owner's name here:**

Owner or Agent **:** Dr Mr Mrs Ms _____Sex: ☐M ☑F Spouse's name:_____
(last) (first) (m.i.)

Address:_____ Apt # _____ City: _____

State: _____ ZIP: _____ Home phone number:_____ Cell phone number: _____

Employer: _____Work Phone: _____ How did you hear about us? _____

Driver license #: _____ Owner Date of Birth____/_____/____ E-Mail _____
(Your DOB is now required by the DEA to dispense controlled medications to your pet)

Your preferred method of payment for today's services: ☐**Cash** ☐**Check** ☐**Visa/MC** ☐**Amex** ☐**Disc** ☐**Care Credit**
All checks are processed electronically. Check signer must be present and have valid identification.

I hereby authorize **Tri-City Veterinary Clinic** to examine, treat and provide necessary care to the above described pet. Should my pet require boarding or hospitalization, I agree to pick up my animal when he/she is ready for release. Failure to retrieve my animal within 5 days of notification that he/she is ready for release will deem the pet abandoned and requires **Tri-City Veterinary Clinic** to handle the animal in accordance with the California Abandoned Animal Act. Abandonment of an animal does not release the owner or agent of financial responsibility for that animal.

I, the undersigned, agree as owner or agent, that in consideration of treatments and services rendered for the above patient, **obligate myself to pay all fees incurred at the time services are rendered. Tri-City Veterinary Clinic does not offer billing**.

I certify that I am at least **eighteen (18) years of age** and that I am the owner or owner's agent of the above mentioned animal and am duly authorized to execute the above and accept its terms. I understand that there is no guarantee of successful treatment and that no such guarantee has been made or offered.

Signature of Owner or Agent _____Date _____

Veterinary care during night time hours is provided at the discretion of the veterinarian in charge. Continuous presence of personnel may not be provided during this time.