



Santa Fe Pet Clinic

~ Owner/Patient Registration ~

Thank you for giving us the opportunity to care for your pet.
PLEASE complete ALL information.

Please Print

Date: _____

Your Name _____ Spouse/Co-Owner _____

Address _____

City _____ State _____ Zip _____

Home Phone (Primary): _____

Work Phone _____

Cell Phone: _____

May We Text You If Needed? YES NO

Email: _____

Employer: _____

Patient Info- PLEASE LIST ALL OF YOUR PETS

Name	Dog	Cat	M	F	Spay/Neuter	Color	Breed	Age/Birthdate

When and where were your pet's last vaccinations given? _____

Please answer a few simple questions so that we may be able to serve you and your pet better:

1. (Y) (N) Do you like to discuss fees prior to services?
2. (Y) (N) Do you feel well informed on preventive medicine for pets?
3. (Y) (N) Are you interested in professional grooming for your pet?
4. (Y) (N) Are there any significant medical problems in your pet's history that we should know about?

If yes, briefly describe _____

5. (Y) (N) Do you anticipate a need to board your pet in our kennel?
6. (Y) (N) Does your pet have any KNOWN drug or vaccination allergies? Please list below

How did you hear about us? Yellow Pages Location/Clinic Sign Facebook

Website Referred By _____ Other _____

→ **PAYMENT IS REQUESTED UPON COMPLETION OF SERVICES** ←

CASH CHECK MASTER CARD VISA DISCOVER

Drivers License# _____ Date of Birth _____

Reason for visit: _____

Owner's/Co-Owner's Signature _____ Thank you!