



COMPLEMENTARY MEDICINE
FOR ANIMALS

HOLISTIC VETERINARY CARE CLIENT & PATIENT REGISTRATION FORM

1969 B Mountain Blvd.
Oakland, CA 94611
510-339-2600

YOUR NAME AND PARTICULARS:

Last _____ First _____ Middle _____

Address _____ City _____ Zip _____

Home Phone # _____ Work # _____ Cell # _____

Email address _____

Occupation _____

Alternate responsible adult (name) _____ Phone # _____

Referred by _____

Primary Veterinarian _____

Family Members: # of adults _____ # of children _____ # of pets _____

PET:

Name _____ Birthdate _____ Age _____

Breed _____ Color / Markings _____

Gender (sex) _____ Spayed Castrated Tattoo I.D. # _____

Who in your household has the primary relationship with this pet? _____

Your reason(s) for bringing your pet here today is (are): _____

Is your pet currently on any medications or supplements? _____

If your pet has had any serious medical problems, allergies or drug reactions in the past, please list them:

When was your pet last vaccinated against: Canine DHLPP _____ Canine Bordetella _____

Canine / Feline Rabies _____ Feline FRCP _____ Feline Leukemia _____

At what hospital(s) was your pet last vaccinated? _____

All fees are to be paid in full when services are performed. This policy helps control costs on which we base our fees. Please check your methods of payment: Cash Check Visa MasterCard ATM

I am financially responsible for the patient described above and agree to pay all fees incurred. I understand that any medical or surgical procedure is attended by some risk and that it is not possible to guarantee the successful outcome of any such procedure. This agreement is in force indefinitely from this date unless I notify the clinic in writing to the contrary.

Your Signature _____ Date _____