

ANIMAL CLINIC OF THE OZARKS

New Client Registration Form

Dr. Robyn Theobald, DVM Dr. Sarah Bailey, DVM Dr. Dawn Field, DVM

Name: _____ Home Phone #: _____

Driver's License # _____ Cell Phone# _____

Email Address _____ Social Security# _____

Mailing Address: _____

Physical Address: _____

Employer: _____ Work Phone #: _____

Spouse or Co-Owners Name: _____ Home Phone # _____

Driver's License# _____ Cell Phone # _____

Email Address _____ Social Security# _____

Mailing Address(if different than above) _____

Physical Address (if different than above) _____

Employer _____ Work Phone# _____

Name: _____

Name: _____

Species: Dog Cat Sex: M F

Species: Dog Cat Sex: M F

Breed: _____ Color: _____

Breed: _____ Color: _____

Birth date/Age: _____

Birth date/Age: _____

Spay/Neuter? _____ Date: _____

Spay/Neuter? _____ Date: _____

AUTHORIZATION *PLEASE READ*

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet(s). I assume all responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment. Estimates are available upon request. Please provide a valid driver's license to copy for our file.

Signature of Owner/Responsible Party: _____ Date: _____

Method of payment: Cash Check/Debit Credit Card (MasterCard/Visa/Discover)