



Lake Union Veterinary Clinic Client/Patient Registration

Contact Information:

Client Name: _____
Last Name First Name MI Spouse/Partner

Address: _____
Number Street City State Zip

Phone Numbers: _____
Home Work Cell Other

Email: _____

Owner Information:

Date of Birth: _____

Employer: _____

Work Address: _____

Drivers License No.: _____

Spouse/Partner Information:

Date of Birth: _____

Employer: _____

Work Address: _____

Drivers License No.: _____

Referral Information:

Client Newspaper	Veterinarian Clinic Sign	Pet Store/Daycare Website	Search Engine Phonebook
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Please provide additional information: _____
Name of client/Veterinarian/Pet Store etc. or other referral source

Patient (Pet) Information:

First Pet: _____
Pet's Name Species Breed Date of Birth

Sex (M/F) Altered (Yes/No) Color/Markings Microchip/Tattoo Number

Second Pet: _____
Pet's Name Species Breed Date of Birth

Sex (M/F) Altered (Yes/No) Color/Markings Microchip/Tattoo Number

Third Pet: _____
Pet's Name Species Breed Date of Birth

Sex (M/F) Altered (Yes/No) Color/Markings Microchip/Tattoo Number

Please Sign The Following Authorization For Treatment (at your first visit):

I hereby authorize the staff of Lake Union Veterinary Clinic to render any treatment that is deemed necessary to my pet(s) health while in custody of the hospital. I understand that in the event of any unusual or emergency circumstances, the staff will make every attempt to contact me or my designated representative before, if time permits, proceeding with treatment. I understand that I will be financially responsible for all emergency procedures including the Estimate of Charges provided to me in person or over the telephone. **I understand that professional fees are to be paid at the time services are rendered and a deposit is required on all pets admitted to the hospital.**

Signature of Owner/Agent/Good Samaritan _____ Date _____ Signature of Spouse/Partner _____ Date _____

