



# 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 \_\_\_\_\_