



New Client Registration

ID#: _____

Date: _____ / _____ / _____

How did you hear about us? : _____

Primary Owner

Name (first/last): _____

Street: _____

City: _____ State: _____ Zip: _____

Phone (home): _____ (cell): _____ (work): _____

Secondary Owner

Name (first/last): _____

Phone (home): _____ (cell): _____ (work): _____

Contact Method

How would you like to be contacted about the following items?

Vaccine Due Date Reminder: Mail e-Mail

Post-Surgery Advisement: Call Text e-Mail

Pre-Appointment Reminder: Call Text

e-Mail address: _____

Payment is due at time of service.

(We accept Cash, American Express, Visa, Master Card, Discover, ATM and Care Credit)

I/We understand and agree that in the event of default, to pay reasonable collection and/or attorney fees.

X _____ / /

Owner's Signature

Owner's Birthday

*(Required by the CA Dept. of Justice
for prescription of certain medications)*