Southwick Veterinary Hospital
St. Louis, MO
(314) 892-0244

CLIENT REGISTRATION

Date:_____

Last Name:_____ First Name:_____

Street:_____

City:_____ State_____ ZIP:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____

Email:_____

Occupation:_____

Employer:_____

Spouse or
Significant
Other Name:_____ Cell Phone:_____

Work Phone:_____ Email:_____

Alternate Contact:_____ _____
(Name) (Phone)

How did you select our hospital? Please mark one

❍ Location ❍ Previously our client ❍ Southwick Website ❍ VAL PAK ❍ LocalVets.com ❍ Yelp Website
❍ Google Search ❍Yellow Pages ❍ St. Louis Today ❍ Angie's List ❍ Care Credit Website
❍ Personal Referral ❍ Other_____

If referred by one of our clients, please list their name so that we may thank them.

_____

PATIENT REGISTRATION

Pet's Name:_____

Species: [ ] Dog [ ] Cat [ ] Bird [ ] Rabbit [ ] Reptile [ ] Rodent [ ] Other

Birth date (approx. if known)_____ [ ] Male [ ] Neutered [ ]Female [ ] Spayed

Breed:_____ Color_____

Vaccination History (Please check those that apply and provide the date of last vaccination):
Canine
[ ] Rabies_____ [ ] DHLPP_____ [ ] Heartworm Test_____

[ ] Bordetella_____

Feline
[ ] Rabies_____ [ ] FVRCP_____ [ ] Feline Leukemia_____

Name of Previous Veterinarian to contact for records:

_____ Phone if known_____

PROFESSIONAL FEES ARE TO BE PAID AT THE TIME SERVICES ARE PERFORMED

WE ARE NO LONGER ABLE TO ACCEPT PERSONAL CHECKS

Sorry for any inconvenience

In admitting my pet(s) for diagnostics, treatment, or surgery, I authorize the veterinarians of Southwick Veterinary Hospital, and their support staff, to administer such treatment and/or perform such diagnostic or surgical procedures as deemed necessary.

It is understood that an estimate of charges will be given for services. No guarantee or assurance can be made as to the results that may be obtained. Further, I realize that these charges may exceed a given estimate if complications arise. I understand that I will be contacted prior to treatment, if possible, should complications occur.

If your account should be turned over to a collection agency or an attorney you will be liable for the fees.

Signature:_____

I will be paying today with:

□ Cash □Credit or Debit: □ Master Card □ Visa □ Discover □ American Express

□ Care Credit (For Services of $ 200.00 or more)

□ I already have a Care Credit Account **□ I wish to apply for a Care Credit Account Or receive information about Care Credit**

NOTE: PLEASE LET THE DOCTOR OR TECHNICIAN KNOW IF YOU NEED AN ESTIMATE FOR TODAY'S VISIT