

Glove Cities Veterinary Hospital

"making a difference, one paw at a time" 



Client Registration Form

Please check one: New client Current client

Name: _____
Last First Middle Initial Spouse

Co-Owner's Name (if any) : _____

Address: _____ Physical Address: _____
Street City, State, Zip Street City, State, Zip

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Email Address: _____ Best number to contact you on: _____ Spouses Phone # _____

Place of Employment: _____ Spouse's Place of Employment: _____

Emergency Contact: _____ Phone: _____

How did you hear about us? (check one)

- Website Phone Book TV Commercial Friend/Family, who can we thank? _____
 Radio Local Channel 18 Other (please specify) _____

Patient Information

Name: _____ Birth Date/ Years Old: _____

Species: (check one) Cat Dog Other: _____

Breed: _____ Sex: Male Female

Color: _____ Spayed/Neutered? Yes No

Where was your pet last examined? _____ When? _____

Can we contact this hospital for your pet's medical history? _____

Is your pet on heartworm preventative? _____

Any long term medical problems? _____

Current Medications: _____

*Do we have permission to use a picture of your pet on our social media? (check one) Yes No

I understand that payment is due at the time of service and that I can pay by cash, check, MasterCard, Visa, Discover Card or Care Credit. I hereby authorize the doctor to examine, prescribe for, and treat the above pet.

Signature: _____ Date: _____