Firetower Animal Clinic
4110 Bayswater Road
Winterville, NC 28590
(252) 830-3800

Client Registration

Owner: ______________________ Co-Owner: ______________________

Owner's Date of Birth: ______________________ Driver's Licence #: ______________________

Primary Phone: ______________________ Secondary Phone: ______________________

Address: ____

Street City State Zip Code

Email: ______________________ Place of Employment: ______________________

We value your personal information. Your email will only be used for notifications from Tenth Street Animal Hospital

Additional Authorized Contact Name and Number: ______________________

You authorize us to speak to this person about your pet's care in the event that we cannot reach you.

What social media platforms do you use? ☐ Facebook ☐ Twitter ☐ Instagram ☐ LinkedIn

How did you hear about us? ☐ Family/Friend ☐ Website ☐ Google/Online ☐ Social Media

If you were referred by a client, please tell us who so we can say thank you. ______________________

New Patient Information

Pets Name ______________________

Dog or Cat Breed: ______________________

Sex: ☐ Male ☐ Female ☐ Neutered ☐ Spayed

Color: ____________ Birthday/Age: ____________

Previous Health Issues: ______________________

____

Pets Name ______________________

Dog or Cat Breed: ______________________

Sex: ☐ Male ☐ Female ☐ Neutered ☐ Spayed

Color: ____________ Birthday/Age: ____________

Previous Health Issues: ______________________

____

Name and number of your pet's previous veterinarian? ______________________

We love social media! We would like your consent to share your pets' image on our social media and website. Your full name and personal information will never be used.

☐ **Yes, Please make my pet a star!!**

☐ No thank you my pet is shy

Treatment Consent: I hereby authorize the veterinarian to examine, prescribe for or treat the above described pet(s). I assume responsibility for all charges incurred in the care of this animal. I understand that **payment is always due in full at the time of service**. I recognize that financial concerns should be discussed prior to exam and treatment. For your convenience we accept Visa, Mastercard, American Express, Care Credit, cash and check with proper identification. Please stop at the reception desk to review and pay for services.

I confirm that the above information is correct and that I am the owner or authorized agent of the patient(s) listed above.

Signature: ______________________ Date: ____________