NEW PATIENT REGISTRATION

Your Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone **#1** _____

Work Phone _____ Cell Phone #2 _____

*Email _____

Please note: Your privacy is important to us.
All information received in all forms and through other communications is subject to our **Patient Privacy Policy.**

PET INFORMATION

Pet's Name _____ Age/DOB _____

Breed Dog / Cat / Other _____ Male / Female
Male / Neuter Female / Spay

Pet's Name _____ Age/DOB _____

Breed Dog / Cat / Other _____ Male / Female
Male / Neuter Female / Spay

Pet's Name _____ Age/DOB _____

Breed Dog / Cat / Other _____ Male / Female
Male / Neuter Female / Spay

Pet's Name _____ Age/DOB _____

Breed Dog / Cat / Other _____ Male / Female
Male / Neuter Female / Spay

Pet's Name _____ Age/DOB _____

Breed Dog / Cat / Other _____ Male / Female
Male / Neuter Female / Spay

I understand that FULL PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED and that a DEPOSIT IS REQUIRED FOR ANY HOSPITALIZED PET. All unpaid balances are subject to a 1.5% per month interest charge. Returned checks are subject to the incurred returned check fee. In the event legal action is required to recover an unpaid balance I agree to pay all interest, court costs and attorney's fees. I authorize the release of my pets' medical records to Fort Mitchell Veterinary Center and hereinafter waive the written release requirement pursuant to KRS 321.185(3)(b)(1).

I have read and understand the above statements and agree to all terms therein.

Signature: _____ Date: _____