



# VETERINARY MEDICAL AND SURGICAL GROUP CLIENT REGISTRATION

AVIMARK CLIENT # \_\_\_\_\_

Please provide us with the following information so that we may provide you and your pet with the finest service possible.

Your Name \_\_\_\_\_ Spouse / Partner \_\_\_\_\_  
Mr / Mrs / Ms / Dr \_\_\_\_\_ First \_\_\_\_\_ Last \_\_\_\_\_

Home Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Fax \_\_\_\_\_ Other Phone \_\_\_\_\_ Email \_\_\_\_\_

How do you prefer to be contacted?  Home  Work  Mobile  Other

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Work Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Driver's License number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_

If we are unable to reach you, who may we contact in case of emergency?:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Do you authorize this person to make urgent treatment decisions if you are unreachable?  Yes  No

Please list additional people we may release information to:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Pet Name \_\_\_\_\_ Species  Canine  Feline Breed \_\_\_\_\_

Date of Birth \_\_\_\_\_ Color \_\_\_\_\_ Sex  Male  Female Neutered  Yes  No

Primary Veterinarian \_\_\_\_\_ Phone \_\_\_\_\_

Presenting Problem / Special Needs / Concerns \_\_\_\_\_

I hereby authorize Veterinary Medical and Surgical Group (VMSG) to render medical care for my pet(s) as deemed necessary by the veterinarian. I understand that no guarantee can be given to the outcome of treatments and take it as my responsibility to comprehend any risks involved. I agree to pay for the cost of all services to which I consent to by written or verbal estimate. I understand that payment is required in full before diagnostics and treatments can be initiated.

Signature \_\_\_\_\_

Date \_\_\_\_\_