



199 Post Road West
 Westport, CT 06880
 (203) 226-1231
 schulhofanimalhospital.com

NEW PATIENT REGISTRATION

Owner's name, Last		Owner's name, First		Spouse/Partner's Name, Last		Spouse/Partner's Name, First	
Home Phone		Business Phone		Cell Phone/Emergency Phone		Partner's Work Phone	
Address			City, State, Zip			E-mail	
SS#		Employer/Business		Address			
Patient's Name		Species: Dog ___ Cat ___ Other ___		Sex: Male ___ Altered Male ___ Female ___ Spayed Female ___			
Breed				Color		Birthdate	
Date of Last Vaccinations: Rabies _____ Feline/K9 Distemper _____ Bordetella _____ Lyme _____ Lepto _____ FeLV _____							
Previous Major Health Problems				Known Drug or Vaccine Allergies			
Please check any symptoms or problems that you have noticed about your pet:							
___ Behavior Problems		___ Bleeding Gums		___ Breathing Problems		___ Coughing	
___ Diarrhea		___ Eyes Bulging or Bloodshot		___ Gagging		___ Limping	
___ Scooting		___ Lack of Appetite		___ Loss of Balance		___ Scratching	
___ Seems Depressed		___ Shaking Head		___ Sneezing		___ Vomiting	
___ Aggression toward people/animals				___ Thirst and/or Increased Urination		___ Other _____	
Is your dog/cat now taking heartworm preventative? Yes _____ No _____				Do you have children? Yes _____ No _____			
How will you pay for this visit today? CASH _____ CHECK* _____ M/C, VISA _____ <small>*only with valid dr. lic. & have been a client over 6 months</small>							
Please tell us how you found out about us (check any that apply): <input type="checkbox"/> on-line directory (which site _____)							
<input type="checkbox"/> yellow pages <input type="checkbox"/> direct mailing <input type="checkbox"/> newspaper <input type="checkbox"/> magazine <input type="checkbox"/> rabies clinic <input type="checkbox"/> SAH web page <input type="checkbox"/> drive by <input type="checkbox"/> Humane Society <input type="checkbox"/> Special Event <input type="checkbox"/> Professional Referral <input type="checkbox"/> other _____ <input type="checkbox"/> friend* _____ *Please give name so we can send them a 'Thank You.'							

The above information is accurate and true to the best of my knowledge and I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet.

I assume responsibility for all charges incurred in the care of this animal, and that these charges will be paid at the time of release. I understand that a credit card number with expiration date and a deposit will be required for surgical treatment or major procedures. In the event of payment default I will pay reasonable attorney's fees and costs of collection. If payment becomes 30 days past due, service charges at an APR of 18% and a \$5.00/month billing fee will be added to the balance due.

Signature of Owner _____ Date _____