Welcome

Registration

Name of Responsible Party(s)_____

Address _____

City _____State _____ Zip _____

Phone(____)_____ Work/Home (___)_____ Other (___)_____

E-mail _____

Social Security Number_____ DL#_____

Employer Name & Address _____

In Case of Emergency, Please Call _____

Pet Health History

Pet Name	Breed/ Species	Male/ Female	Spayed/ Neutered?	Color	Age/DOB
			YES/NO		
			YES/NO		
			YES/NO		
			YES/NO		

Known Medical History/ Previous Veterinarian/ Current Medications:

_____

_____

Authorization

I hereby authorize Eastside Pet Clinic to examine, prescribe for, or treat the above described pet(s). I am 18 years or older and assume responsibility for all charges included in the care of this animal(s). I understand that a deposit may be required for certain treatments. It is understood that if accounts are not paid in full at time of service a processing and/or billing fee may be applied and the account may be turned over to collections.

Signature _____ **Date** _____

Eastside Pet Clinic * 285 S. Woodruff Ave * Idaho Falls, ID 83401