Animal Wellness and Healing Center
Client Registration

Name_____ Spouse _____
Last First Last First

Address_____
Number Street City Zip Code

Home Phone_____ Cell Phone _____

Spouse's Cell Phone_____ *Email* _____

Birthdate _____ Social Security #_____ Driver's License_____

Place of Employment_____ Phone Number_____

Spouse's Employment _____ Phone Number_____

Spouse Birthdate_____ Spouse Social Security#_____

Spouse Drivers License #_____

Referred by_____

Professional Fees must be paid at the time the services are rendered.

The parties agree that a finance charge of 1 ½ % per month shall be charged on any balance due and owing on the account for more than 30 days. The annual percentage rate (APR) is 18%.

SIGNATURE OF OWNER_____DATE_____

IF OTHER THAN OWNER:
Signature_____ Date_____

Street_____ City_____ Zip Code_____

Telephone _____ Relationship to owner_____

Please provide all vaccination records for your pets

Animal Wellness and Healing Center sincerely appreciate your cooperation for providing all necessary previous medical and surgical information for your pets.

Previous Veterinarian / Office_____
Address_____
Phone number_____ fax_____

Initial here_____ to give your permission to have pets records released to:
Animal Wellness and Healing Center

How would you prefer correspondence with our office: phone call ____, text_____, email____, post card____.