

Black Horse Animal Hospital Client Registration Form

CLIENT INFORMATION

Owner's name: _____

Secondary name on account (Optional): _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

CONTACT INFORMATION

Cell: _____ Secondary Number: _____

Home: _____ Work: _____

Email: _____

How do you prefer to be contacted: Cell: _____ Work: _____ Home: _____ Email: _____

How did you hear about us: _____

**We are now asking our clients permission before posting pictures of our patients on our website or Facebook page.
Please check the appropriate box below**

- Yes, I give permission for BHAH to use pictures of my pet
 No, please do not use photos of my pet

PATIENT INFORMATION

Pet's Name: _____ Birth Date: __/__/__

Breed: _____ Color: _____ Sex: _____

Spayed/ Neutered: _____ Microchip: YES NO IF YES, Microchip#: _____

Pet's Name: _____ Birth Date: __/__/__

Breed: _____ Color: _____ Sex: _____

Spayed/ Neutered: _____ Microchip: YES NO IF YES, Microchip#: _____

Previous Vet: _____ Records faxed: _____

**WE PROCESS CHECKS THROUGH TELECHECK
IF YOUR CHECK IS DECLINED WE WILL REQUIRE ANOTHER FORM OF PAYMENT**

I certify that I am at least 18 years old and am authorized to request services from Black Horse Animal Hospital. I assume full financial responsibility and understand payment is due at time of service. Pets will be retained until payment is received in full.

Signature: _____ Date: _____