ARLINGTON CAT CLINIC – REGISTRATION FORM

CLIENT INFORMATION *(please print clearly)* Date_____

Owner Name: (*)_____ Spouse _____

*(Must be 21 years of age or older)

Address_____City_____Zip_____County_____

Home Phone ( )_____**Email**_____

Owner Employer_____Phone ( )_____Cell ( )_____

Spouse Employer _____ Phone( )_____Cell ( )_____

For check writing privileges, please provide your:

Social Security#____-____-____ & Driver's License # _____

PET INFORMATION

Name_____Breed_____Color_____Sex_____

(Circle one) SPAYED? NEUTERED? Date of Birth_____or Age_____

DECLAWED? **(circle one)** Front only / all 4 paw declaw / NOT DECLAWED

VACCINATION HISTORY ***(please indicate date or month and year of vaccine)***

Distemper_____Rabies_____Leukemia_____Other_____

Feline Leukemia test (Felv) Date_____ Result_____FIV test? Date_____Result_____

How old was your cat when you acquired it? _____ Does your cat go outside? _____

Where did you acquire your cat? (Circle one) breeder shelter store stray private home

How many other pets are in your household? cats _____ dogs_____Other_____

What brand of food do you feed? Dry _____ Canned_____

Prior illnesses or surgeries? _____

Any known allergies or vaccine reactions?_____**Microchip #**_____

Is your cat: Just a pet or a member of the family? **(circle one)**

****How did you become aware of us?** Yellow pages_____Hospital Sign_____Internet_____Magazine_____

Personal Recommendation from (name) _____

I grant Arlington Cat Clinic permission to post my cat's photo, and story on social media Yes_____No_____

If yes, (signature required)_____

*****PROFESSIONAL FEES ARE TO BE PAID AT THE TIME SERVICES ARE RENDERED*******

In admitting my pet(s) for diagnostics, treatment, or surgery, I authorize the doctors of Arlington Cat Clinic, Ltd. and their support staff, to administer such treatment and /or perform such diagnostic or surgical procedures as deemed necessary. It is understood that an estimate of charges will be given for hospitalizations and surgeries. No guarantee or assurance can be made as to the results that may be obtained. Further, I realize that these charges may exceed a given estimate if complications arise. I understand that I will be contacted prior to treatment, if possible. I agree to pay Arlington Cat Clinic, Ltd. at the time services are rendered. If the account goes delinquent; no payment in 30 days, the account will be assessed a 2.00% billing fee on the outstanding balance (24% yearly). I further agree if the account is transferred to collections, I will be responsible for all the costs necessary to collect this balance including collection fees, costs, and filing fees. If a check is returned non-sufficient funds, a minimum of $25.00 will be added to the amount owed.

SIGNATURE _____ **DATE**_____