West Chester Veterinary Medical Center

1141 West Chester Pike, West Chester, PA 19382
610 696-8712

Client Patient Registration

Welcome to our practice. Thank you for giving us the opportunity to serve you and your special companion. Please complete this registration form so that we may establish a medical record for your pet.

Client's Name____________________

Spouse/Other____________________

Address____________________

City____________________ State__________ ZIP__________

Home Phone ( ) ____________________ Home Fax ( ) ____________________

Work Phone ( ) ____________________ Cell ( ) ____________________

Spouse Work ( ) ____________________ Spouse Cell ( ) ____________________

Preferred number to call ( ) ____________________ Best time to reach you ____________________

E-Mail____________________

Please provide the following information about your pets(s):

1. Name ____________________Species__________ Breed____________________

   Color__________ DOB____________________ Sex____________________

   Spayed or Neutered? (check one) ❑ Yes ❑ No Microchipped? (check one) ❑ Yes ❑ No

2. Name ____________________Species__________ Breed____________________

   Color__________ DOB____________________ Sex____________________

   Spayed or Neutered? (check one) ❑ Yes ❑ No Microchipped? (check one) ❑ Yes ❑ No

3. Name ____________________Species__________ Breed____________________

   Color__________ DOB____________________ Sex____________________

   Spayed or Neutered? (check one) ❑ Yes ❑ No Microchipped? (check one) ❑ Yes ❑ No

All fees are due at the time of service. We accept Visa, Mastercard, debit cards, personal checks and cash. In the event of extensive medical or surgical procedure, you may wish to apply for Care Credit, a service that provides a 90 days interest free credit line for approved applicants. There is a $35 service charge for any check returned unpaid.

Signature of owner/agent of pet(s) ____________________ Date: __________

How did you hear about us? ____________________