



# 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 pet(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? \_\_\_\_\_