SOUTHCENTRAL VETERINARY SERVICES

Dr. Eddy Grimes
542 Plum Springs Loop
Bowling Green, KY 42101
P: 270-282-2564 F: 270-282-2563

New Client Registration Form

We appreciate the opportunity to care for your pet.
PROFESSIONAL FEES ARE TO BE PAID AT THE TIME SERVICES ARE RENDERED.

OWNER NAME _____ DATE_____
MAILING ADDRESS_____
CITY _____STATE_____ZIP_____
HOME #_____CELL #_____
EMAIL ADDRESS_____
Would you like to receive email reminders? _____

EMPLOYER_____

SPOUSE/OTHER_____
MAILING ADDRESS_____
SPOUSE/OTHER HOME #_____CELL #_____
EMAIL ADDRESS_____
Would you like to receive email reminders? _____

EMPLOYER_____

How did you hear about us? _____

***Please initial all statements below:**

_____ I do hereby request veterinary care to be provided for pet(s) presented by me of my agents. I also authorize Southcentral Veterinary Services to perform any and all operations which are deemed necessary by them for the welfare of any animal placed by me in their custody.

_____ I understand that I assume all financial responsibility and furthermore

_____ I understand that payment is due in full at the time services are rendered.

	Pet 1	***Pet 2***	***Pet 3***
Name	_____	_____	_____
Date of Birth	_____	_____	_____
Age (Years)	_____	_____	_____
Species (Cat, Dog, Other)	_____	_____	_____
Breed	_____	_____	_____
Sex	_____	_____	_____
Neutered/Spayed	**Neuter/Spayed/Intact**	**Neuter/Spayed/Intact**	**Neuter/Spayed/Intact**
Color	_____	_____	_____
Length of Time Owned	_____	_____	_____
Microchip #	_____	_____	_____
Medical Alert	_____	_____	_____
Food/Drug Allergies	_____	_____	_____
Kind of Pet Food	_____	_____	_____
Kind of Grooming Products	_____	_____	_____

Vaccination History

Rabies	_____	_____	_____
DHLP-Parvo (Distem-Dog)	_____	_____	_____
Heartworm Test	_____	_____	_____
Heartworm Prevention	_____	_____	_____
Bordetella (Dog & Cat)	_____	_____	_____
FVRCP-P (Infectious Dis.-Cat)	_____	_____	_____
Feline Leukemia Vaccine	_____	_____	_____
Fecal Check (Worms)	_____	_____	_____
Dentistry	_____	_____	_____
Prior Illness	_____	_____	_____
Prior Surgery (list)	_____	_____	_____

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542 Plum Springs Loop • Bowling Green, KY 42101
Eddy Grimes, DVM • 270-282-2564 • 270-282-2563 (fax)

Authorization to Release Veterinary Records

Pet Owner Information:

Name:_____

Address:_____

City:_____State:_____Zip Code:_____

Telephone:_____

Email Address:_____

Pet Information:

Name:_____Breed:_____
Name:_____Breed:_____
Name:_____Breed:_____
Name:_____Breed:_____

Information to be released includes:

____Entire Medical Record _____Vaccination History Only _____Current Vaccination Status Only

Southcentral Veterinary Services will need the information requested from the following:

Clinic/Hospital Name:_____Telephone:_____

Veterinarian Name:_____

Address:_____Fax:_____

City:_____State:_____Zip Code_____

I hereby certify that I am the owner or authorized agent of the owner of the above described pet(s). Further, I hereby request and authorize the release of the requested medical information for my pet(s) from the above named facility to Southcentral Veterinary Services. I release the above named facility and their veterinarians and staff from any and all legal liability to receive this information to the extent indicated and authorized herein. I may revoke this authorization in writing at any time.

_____ _____
Owner Signature Date