

|  |  |  |
| --- | --- | --- |
| **Good Shepherd Veterinary Hospital** |  Welcome | **101 Fox Trot Dr****Mars, PA 16046****Tel: 724 776 PETS****Fax: 724 776 7388**[**www.gsveterinaryhospital.com**](http://www.gsveterinaryhospital.com) |

**Client Registration**

**Owner**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Last Name |  | First Name |  | SS# |
|  |  |  |  |  |  |  |
| Street Address |  |  City |  | State |  | Zip Code |
|  |  |  |
| Home Phone # |  | Cell / Pager |
|  |  |  |
| Occupation |  | Work # |
|  |  |  |
| Email Address |  | Driver’s License # |
|  |  |  |  |  |
| Spouse’s Name |  | Last Name |  |  Occupation |
|  |  |  |  |  |
| Work |  | Cell / Page |  | SS# |

**How did you hear about our facility?**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Google |  | Advertisement |  | Friend  |  | Radio/TV |  | Yellow Page |  | Other |

**Patient Registration**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |
| Your Pet’s Name |  |  | Species |  | Canine |  | Feline |  | Avian |  | Other |
|  |  |  |  |  |
| Date of Birth  |  | Breed |  | Color /Marking |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Gender |  | Male |  | Female |  | Spayed / Neutered |  | Not Spayed / Neutered |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Vaccination History |  |  | Rabies |  | FVRCP/ DHPPL |  | Feline leukemia |  | Other |

|  |
| --- |
| Dates |

Medication / Dosages

**Authorization for Medical Treatment**

 **I hereby authorize Good Shepherd Veterinary Hospital Professional Staff to examine, prescribe, treat, and / or utilize procedures or tests deemed necessary for my above described pet to insure the best possible care. I assume responsibility for all charges incurred to my pet. I understand that payment is due at the time services are rendered and that GSVH does not bill. A deposit is required if non-elective hospitalization is necessary. An estimate is given** **upon request.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Signature of Owner or authorized agent |  | Spouse’s signature |  | Witness (Employee) |

Office use only:

 Registration date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Computer # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_