

ALL FOR PAWS ANIMAL CLINIC

reception@allforpawsanimalclinic.com

Client Registration Form



Owner's Last Name: _____ Owner's First Name: _____

Co-Owner's Name: _____

Mailing Address: _____

Street Address: _____

City, State, Zip: _____

Primary Phone Number: _____

Primary Cell Phone Number: _____

Work Phone Number: _____

E-mail Address: _____

How do you prefer to be contacted: Email, Text, Phone call? _____

In the event we cannot reach you, please provide an emergency contact:

Name: _____

Relation: _____

Phone: _____

How did you become aware of our clinic? _____

By signing below, you understand that there may be times where veterinary students are working in our facility under direct supervision of the veterinarian on staff and will have contact with the patient.

By signing below you understand that professional fees are to be paid at the time services are rendered. We do not carry open accounts. *We accept cash, Master Card, Visa, American Express, Discover, Scratch Pay, and Care Credit. We do not accept personal checks.* In cases where in-hospital, emergency care, or hospitalization is required, a deposit prior to treatment may be required. We reserve the right to require pre-payment for any estimated services. I, the undersigned, have read and understand the payment policy of All For Paws Animal Clinic.

Signature: _____

Date: _____

Created By: _____

Uploaded By: _____

ALL FOR PAWS ANIMAL CLINIC

reception@allforpawsanimalclinic.com

Patient Registration Form



Owner's Name: _____ Date: _____

Patient's Name: _____

Species (Cat or Dog): _____

Breed: _____

Coat Color: _____

Sex: _____

Birthdate/Age: _____

Spay/Neuter: Yes No

Microchipped: Yes No

Medical Alerts: *Yes or No*

Aggressive with other pets _____

Biter _____

Sensitive to anesthesia/sedatives? _____

Antibiotic sensitive _____

Seizures _____

Vaccine reaction _____

Nervous at the vet _____

Known medical conditions _____

Is your pet currently taking any medication? If so, what kind and how often? _____

List all known allergies or reactions to medications: _____

Is there anything you'd like us to know about your pet? _____

Has your pet been seen by another clinic? If so, what is the name of the clinic and may we call for records?

Created By: _____

Uploaded By: _____

Virginia Veterinary Disclosure Form

(Please read carefully before signing)

All For Paws Animal Clinic has business and medical staffing hours as follows:

Monday – Friday 7:30 a.m. until 6:00 p.m.
Saturday..... 8:00 a.m. until 1:00 p.m.
Sunday (boarding pick-ups only) 5:00 p.m. until 6:00 p.m.

The clinic is closed on Sunday and on holidays; therefore this is to inform you that we have no in-house, on-duty continuous medical staff care:

- Overnight, from closing time at 6:00 p.m. to opening time at 7:30 a.m. (8:00 a.m. on Saturday);
- Weekends, from closing time at 1:00 p.m. on Saturday to opening time at 7:30 a.m. on Monday morning;
- Holidays, from closing time at 6:00 p.m. the day before the holiday to opening time at 7:30 a.m. the day after the holiday (8:00 a.m. on Saturday);
- Holidays falling on Monday, from closing time at 1:00 p.m. on Saturday to opening time at 7:30 a.m. on Tuesday.

I have read this form and I am aware of the clinic's hours of operation, as well as the hours of in-house, on-duty continuous medical staffing.

Client Signature _____ Date _____

Photo Release Form

All For Paws Animal Clinic
175 Shoppers Way
Christiansburg, VA 24073

I grant to All For Paws Animal Clinic and its employees permission to take photographs of me and/or my pet(s). I understand that this photo may be used for social media and/or as a marketing tool.

Signature

Printed Name

Date