LRVC- Client Registration

Name: ____

Address: ____ APT: ______________

City: _________________________ State: ________ Zip: __________________

Email: ____

Home Phone: ___________________________ Cell Phone: ___________________ OK to Text: Y or N

Spouse Name: ________________________ Spouse Phone: ___________________________

How did you hear about us? ____

Pet(s) Info:

Name	Canine/Feline	Breed	Color	Sex/Altered	Age	Microchip

Consent for the release of medical records (Please initial all that apply)

____ I authorize Laurel Road Veterinary Clinic (LRVC) to release/disclose my pet's health and medical records to any veterinary facility that may request them.

____ I authorize the LRVC to release/disclose my pet's health and medical records to any grooming/boarding/pet care facility that may request them.

____ I authorize that LRVC to release/disclose my pet's health and medical records only to the facilities listed: ____.

____ I do NOT authorize the LRVC to release/disclose my pet's health and medical records without prior

_____ written OR ____ verbal consent.

Please sign the following authorization for treatment: ***I hereby authorize the staff of LRVC to render any treatment that is deemed necessary to my pet(s) health while in the care and/or custody of the clinic. I understand that I will be financially responsible for all services and/or treatment(s). We may provide an estimate of costs which may be subject to change. I understand that payment is due at the time services are rendered and a deposit may be required when pets are admitted to the clinic.***

Signature: ____ Date: ________________