



VETERINARY MEDICAL AND SURGICAL GROUP CLIENT REGISTRATION

AVIMARK CLIENT # _____ / AVIMARK PATIENT # _____

Please provide us with the following information so that we may provide you and your pet with the finest service possible

Your Name _____ Spouse / Partner _____
Mr. / Mrs. / Ms / Dr First Last

Home Address _____ Apt # _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Fax _____ Other Phone _____ Email _____

How do you prefer to be contacted? Home Work Mobile Other Phone

How did you learn about VMSG? Primary Care Veterinarian Internet Social Media Other _____

Employer _____ Occupation _____

Work Address _____

City _____ State _____ Zip Code _____

Driver's License number _____ Date of Birth _____

Social Security Number _____

If we are unable to reach you, who may we contact in case of emergency?

Name _____ Phone _____

Name _____ Phone _____

Do you authorize this person(s) to make urgent treatment decisions if you are unreachable? Yes No

Do you authorize this person(s) (in addition to your primary care veterinarian) to receive patient information? Yes No

Pet Name _____ Species Canine Feline Breed _____

Date of Birth _____ Color _____ Sex Male Female Neutered Yes No

Primary Care Facility _____ Phone _____

Primary Care Veterinarian(s) _____

By listing your primary care veterinarian above, you are authorizing VMSG to release patient information to the primary care hospital or veterinarian.

Presenting Problem / Special Needs / Concerns

I hereby authorize Veterinary Medical and Surgical Group (VMSG) to render medical care for my pet(s) as deemed necessary by the veterinarian. I understand that no guarantee can be given to the outcome of treatments and take it as my responsibility to comprehend any risks involved. I agree to pay for the cost of all services to which I consent to by written or verbal estimate. I understand that a deposit is required before diagnostics and treatments can be initiated and that payment in full is required prior to discharge of patient from VMSG.

Signature _____

Date _____