

New Patient Registration

Thank you for giving P.A.W.S the opportunity to care for your pet. We'll be happy to answer any questions you have about your pet's health. To insure the best care possible, please take time to fill in this form completely. Thank you!

Your Name: _____

Spouse/Co-owner: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Cell Phone #2: _____

Email Address: _____ (please print)

*Please subscribe me to the FREE Pet Living & Wellness News Letter as well as email reminders, and surveys: Yes **No**

*Please note: Your privacy is important to us. All information received in all forms and through other communications is subject of our Patient Privacy Policy & Red Flag Law.

Emergency Contact: _____ Phone: _____

How did you learn of our clinic? Web Page Sign Veterinary Referral
 Other Radio Newspaper Yellow Pages Recommendation

If Recommendation/Referral who can we thank? _____

Please initial each of the following:

- I hereby authorize the veterinarian to examine, prescribe for, or treat my pet (s).
- I am aware that trained personnel will not be here beyond regular hours.
- I understand it is my responsibility to inform the veterinary care team with relevant information regarding my pet's health, diet, medications, supplements, and/or treatments. Serious and sometimes fatal consequences can result from result withholding medical information.
- I am aware that **ALL PAYMENTS ARE DUE AT TIME OF SERVICES RENDERED.** We accept cash, checks, CareCredit, Visa/Mastercard and American Express. P.A.W.S. does not have a payment plan available but we do offer CareCredit through an independent creditor for your convenience.
- I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid at the time of release and a deposit may be required for drop-off/surgical treatment.
- I am 18 (or older) and agree by signing below that I am the person responsible for the care and well being of my pet(s).
- I am under 18 and/or not the owner of the animal. In this is the case I am aware that P.A.W.S. provides a Power of Attorney letter that must be signed for me to provide care for the pet(s) being seen today.

Signature of Owner/Co-Owner: _____ Date: _____

Pet(s) Information

Pet's Name: _____ Age/DOB: _____

Male / Neutered / Female / Spayed (circle) Does your pet have a Microchip? Yes No

Breed: _____ Species: Dog / Cat / Other Color: _____

Lived with Since: _____ Native to Arizona ? Yes No If no, where born? _____

Approx. hours spent outdoors: _____ Places Pet Travels: _____

Is your pet on any special supplements/medications? Yes / No if yes, what? _____

Previous Medical Problems: _____

Any Known Allergies to Vaccinations or Medication? _____

Recent changes in the home environment? If yes, please explain: _____

Other Pet's? Yes No If yes, please list: _____

(if bringing in more than one pet for an appointment – please print a page for each pet)

FOR REFERRAL PATIENTS ONLY

As a referral to PAWS, it is important to note that for all routine care services, including laboratory services, vaccinations, surgeries, and dentistry, will be transferred back to your primary care provider. To facilitate informed and exceptional care for your pet, PAWS Integrative Veterinary Center will contact your primary care veterinarian via fax or phone, summarizing your pet's alternative or rehabilitative evaluation.

My primary care veterinarian or hospital is: _____

To the best of my knowledge the information, about my pet, is represented correctly.

Signature of Owner/Co-Owner: _____ Date: _____