# Client and Patient Registration

Today's Date: _____

Last Name _____ First Name _____ Middle Initial ____
Address _____County_____
Home (____) ____ - _____ Cell (____) ____ - _____ Work (____) ____ - _____
E-mail: _____

Alternate Contact
Name: _____ Phone _____

★★Please bring a copy of all previous medical records with you to your pet's first visit to ★★
★★Belle Meade Animal Hospital.★★

Pet's Name _____
[ ] Dog [ ] Cat Breed: _____
Birthdate (approximate if unknown) _____ [ ] Male [ ] Female [ ] Neutered [ ] Spayed
Color _____ Microchip Number _____

Pet's Name _____
[ ] Dog [ ] Cat Breed: _____
Birthdate (approximate if unknown) _____ [ ] Male [ ] Female [ ] Neutered [ ] Spayed
Color _____ Microchip Number _____

Pet's Name _____
[ ] Dog [ ] Cat Breed: _____
Birthdate (approximate if unknown) _____ [ ] Male [ ] Female [ ] Neutered [ ] Spayed
Color _____ Microchip Number _____

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I understand that all payments are required at the time services are rendered.

I understand that if payment is not made, Belle Meade Animal Hospital will send an account statement. All mailed statements will include a handling fee and any applicable finance charges.

Delinquent accounts are subject to collection and I understand that I will be responsible for all additional service charges, collection costs, court costs, and attorney fees.

I have read and agree to the above.

_____ _____
Client or Agent Signature Date