Registration Form

OREV SPECIALTY VET CARE

OWNER INFORMATION

First Name _____ Last Name _____

Address _____ City _____ Zip _____

Email Address _____ Cell Phone _____

Co-owner _____ Co-owner Phone _____

Co-owner Email _____ Home Phone _____

Do you authorize this person to make urgent decisions if you are unreachable? ☐ Yes ☐ No

PET INFORMATION

Pet Name _____ ☐ Canine ☐ Feline ☐ Male ☐ Female Age/DOB _____

Neutered/Spayed? ☐ Yes ☐ No Breed _____ Microchip? ☐ Yes ☐ No

Primary Veterinarian(s), clinic name: _____

By listing your primary care veterinarian above, you are authorizing our hospital to release patient information to the additional hospital or veterinarian(s) listed. Are there any other veterinarians to whom you would like us to send updates or information? (If yes please list here)

_____

Reason For your visit today? _____

_____

Special needs /concerns _____

Special diet /food allergies _____

How did you hear about us? _____

Were you referred for this visit? ☐ Yes ☐ No

Can we share your pet's pictures on our social media? ☐ Yes ☐ No

I hereby authorize OREV 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 my pet from OREV.

Signature _____ **Date** _____

Owner's printed name for consent:
(in case you can't sign above) _____