



**Client/Owner Registration Record (All Areas Must Be Completed)**

OWNER:

\_\_\_\_\_  
FIRST LAST PRONOUN PREFERENCE: \_\_\_\_\_

SPOUSE/PARTNER:

\_\_\_\_\_  
FIRST LAST PRONOUN PREFERENCE: \_\_\_\_\_

ADDRESS:

\_\_\_\_\_  
NUMBER AND STREET

\_\_\_\_\_  
CITY, STATE, ZIP

PHONE:

PREFERRED CONTACT#  Home  Cell ALTERNATE CONTACT#  Home  Cell

EMAIL: \_\_\_\_\_

Drivers License# (Required) \_\_\_\_\_ EXP. DATE: \_\_\_\_\_ STATE: \_\_\_\_\_

DATE of BIRTH (Required) \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
NAME

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_  
NUMBER AND STREET CITY ZIP

**IF YOU ARE UNAVAILABLE, WHOM SHOULD WE CONTACT IN CASE OF EMERGENCY?**

\_\_\_\_\_  
NAME RELATIONSHIP PHONE

**HOW DID YOU HEAR ABOUT US?**

Website  Facebook  Tucson Weekly  Hospital Sign  Other \_\_\_\_\_  
 Personal Recommendation (Whom may we thank?) \_\_\_\_\_

I hereby grant Acacia Animal Hospital permission to release and/or use photographs of my pet(s) on social media, in emails, and via other formats. I understand and agree that no notice of, nor compensation for such use will be offered to me if I agree.  YES  NO

**ALL FEES ARE DUE AT TIME OF SERVICE**

**\*\*Acacia Animal Hospital does not accept personal checks as a form of payment.**

**\*\*I agree to pay at the time of service, for all the services rendered,** unless otherwise and previously arranged with hospital admission. By signing below, I, or my agent, hereby authorize the doctor(s) at Acacia Animal Hospital to diagnose, prescribe and treat my animals.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



### Pet Information Record

PET #1		PET #2	
<b>Name</b>		<b>Name</b>	
<b>Species</b>		<b>Species</b>	
<b>Breed</b>		<b>Breed</b>	
<b>Color</b>		<b>Color</b>	
<b>Birth Date</b>		<b>Birth Date</b>	
<b>Sex</b>		<b>Sex</b>	
<b>Spayed/ Neutered</b>		<b>Spayed/ Neutered</b>	
Prior Surgery or Illness: _____ _____		Prior Surgery or Illness: _____ _____	
Special Diet or Medications: _____ _____		Special Diet or Medications: _____ _____	
Drug Allergies: _____ _____		Drug Allergies: _____ _____	
Vaccine History: _____ _____		Vaccine History: _____ _____	