Countryside Hospital for Animals
3435 Maughon Road
Covington, GA 30014
Phone 770-787-4711 Fax 770-787-0981
Countrysidevets.com

We know that your pet's health is important and we thank you for trusting us to care for them. To help us provide the best care possible, please take a few moments to fill out this form.

REGISTRATION – CLIENT INFORMATION

(Owner/Responsible Person Must Be 18 Years of Age or Older)

Owner/Responsible ____________________________________Date:________

Secondary Name (Spouse, Parent, Etc.)_______________________________

Address:____

City:_________________ State:___________________ Zip Code:___________

Home No.: _____________________ Cell Phone:_________________________

Email:____

Employer:____________________________________ Work No.: ___________

Date of Birth:__________________ Driver License #:____________________

PET HEALTH HISTORY

Pet #1

Pet's Name: ___________________________ Date of Birth_________________

Species: Canine/ Feline Other: ____

Breed: ____________________________ Color/Markings: __________________

Sex: ______ Has the patient been Spayed or Neutered ___________________

Current on Vaccinations? YES   NO (Circle One)

Previous Veterinarian: _____________________________ Phone ___________

Pet #2

Pet's Name: _____________________________ Date of Birth:______________

Species (circle one): Canine Feline Other: _____________________________

Breed: ____________________________ Color/Markings: _________________

Sex: ___________Has the patient been Spayed or Neutered: _____________

Current on Vaccinations?   YES   NO (Circle One)

Previous Veterinarian: _____________________________ Phone ___________

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for and/or treat the above described pet. I assume full responsibility for all charges incurred for the care of this animal. I also understand that these charges will be paid at the time of release and that a 50% deposit is required for all hospitalized patients.

Owners Signature: _____________________Date ___________________

METHOD OF PAYMENT: (PLEASE CIRCLE ALL THAT APPLY)
CASH CHECK VISA/MC AMERICAN EXPRESS DISCOVER CARECREDIT

Credit Card # ____