

OAKLAWN ANIMAL HOSPITAL
655 OAKLAWN AVENUE
CRANSTON, RI 02920
401-943-0500

CLIENT REGISTRATION FORM

Date: _____

Owner's Name _____ Spouse/Other _____

Children Name(s) & Age(s) _____

Address _____ City _____

State _____ Zip Code _____ Home Phone _____

Work Phone _____ Cell Phone _____

Email: _____

Employer's Name & Address _____

Spouse's/Other's Employer & Address _____

At what number _____ and at what time _____ is best to call about your pet?

In case of EMERGENCY, please call _____ at telephone number _____

Pet's Name _____ Date of Birth _____

Species: () Dog () Cat () Other _____ Sex: () Male () Neutered () Unneutered

Breed _____ () Female () Spayed () Unspayed

Color _____

Reason for Visit? _____

Previous Veterinarian(s) where past medical records can be obtained if necessary:

Has your pet been treated for any illness in the past year? () No () Yes

Specify problem(s), medications & dosage, if known _____

How did you hear of us? () Current/Previous Client Whom may we thank? _____

() Internet/Website () Yellow Pages () Other _____

List name & types of other animals you have at home _____

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 that a deposit may be required for surgical treatment.

Signature of Owner or Responsible Party _____

Driver's License Number _____ State _____