New Client & Patient Registration Form

We would like to know a little about you and your family. Please fill out below.

Client/Owner Information:

Owner Name: LAST NAME FIRST NAME MI _____ Date of Birth: MM/DD/YYYY _____
(Required for Dispensing of Controlled Substances)

Address: STREET APT # CITY STATE ZIP _____

Phone Numbers: ( ) MOBILE _____ ( ) OTHER _____

Email: _____

Secondary Contact: LAST NAME FIRST NAME _____

Relationship: _____ Phone Number: ( ) _____

Email: SECONDARY CONTACT EMAIL _____

Preferred method to contact you with pet health status:
☐ Call ☐ Text ☐ Both

Preferred method of receiving updates and reminders regarding your pet(s):
☐ E-mail ☐ Text ☐ Both

Do you authorize the secondary contact listed to make medical decisions, including lifesaving and financial decisions, regarding your pet in the event we are unable to reach you?
☐ Yes ☐ No

How Did You Hear About Us? (Please Circle One)
Driving by Google Yelp Facebook Instagram NextDoor Referral Other

If Referred by client, please list client name: _____

If Other, please explain: _____

Lincoln Animal Hospital Referral Rewards Program

Refer us to a friend and get a $20 gift card to use towards your next visit when they come in for an appointment.* New clients get 50% off their first exam!

*New clients must note referring client on New Client & Patient Registration form in order to qualify for $20 gift card.

We would like to know about your furry family. Please fill out below.

Patient/Pet Information:

Pet #1

Pet Name: _____
Species: ☐ Feline ☐ Canine
Breed: _____
Color: _____
DOB: _____
Sex: ☐ Male ☐ Female
Spayed/Neutered?
☐ Yes ☐ No
Microchipped: ☐ Yes ☐ No
Any Known Allergies: _____
_____
_____
_____

Pet #2

Pet Name: _____
Species: ☐ Feline ☐ Canine
Breed: _____
Color: _____
DOB: _____
Sex: ☐ Male ☐ Female
Spayed/Neutered?
☐ Yes ☐ No
Microchipped: ☐ Yes ☐ No
Any Known Allergies: _____
_____
_____
_____

Pet #3

Pet Name: _____
Species: ☐ Feline ☐ Canine
Breed: _____
Color: _____
DOB: _____
Sex: ☐ Male ☐ Female
Spayed/Neutered?
☐ Yes ☐ No
Microchipped: ☐ Yes ☐ No
Any Known Allergies: _____
_____
_____
_____

Pet #4

Pet Name: _____
Species: ☐ Feline ☐ Canine
Breed: _____
Color: _____
DOB: _____
Sex: ☐ Male ☐ Female
Spayed/Neutered?
Yes No
Microchipped: ☐ Yes ☐ No
Any Known Allergies: _____
_____
_____
_____

Occasionally, we like to post adorable pictures of our client's pets to our Facebook/Instagram pages or on our website, Client privacy is of the upmost importance at Lincoln Animal Hospital. Your First and last name will not be disclosed or printed at any time unless you wished to be tagged. We are asking for permission to share, print, post and reference your pet's name and picture only.

_____I understand the above statement and I give staff permission to take photos of my pet(s) for records purposes and to publish those photo(s) for any lawful purpose, including but not limited to social media, website or promotional materials, and I waive any rights of privacy or compensation associated with the use of my pet's/pets' image(s). ☐ Yes ☐ No

Please Initial and Sign the Following Authorization for Treatment:

_____ I hereby authorize the staff of Lincoln Animal Hospital to render any treatment which is deemed necessary to my pet(s) health while in custody of the hospital.

_____ I understand that in the event of any unusual or emergency circumstances, the staff will make every attempt to contact me or my designated representative before, if time permits, proceeding with treatment.

_____ I understand that I will be financially responsible for all emergency procedures including the Estimate of Charges provided to me in person, over the phone, or through email.

_____ I understand that professional fees are to be paid at the time services are rendered and a deposit is required on all pets admitted to the hospital. (We do not offer payment plans)

X_____ **Date:** _____ **X**_____ **Date:** _____

Signature of: Owner Agent Good Samaritan
(Please Circle one)

Signature of Spouse (if applicable)