



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 <small>(Required for Dispensing of Controlled Substances)</small>
Address: STREET		APT #	CITY STATE ZIP
Phone Numbers: () MOBILE () OTHER			Preferred method to contact you with pet health status: <input type="checkbox"/> Call <input type="checkbox"/> Text <input type="checkbox"/> Both
Email: _____			Preferred method of receiving updates and reminders regarding your pet(s): <input type="checkbox"/> E-mail <input type="checkbox"/> Text <input type="checkbox"/> Both
Secondary Contact: LAST NAME		FIRST NAME	
Relationship: _____		Phone Number: () _____	
Email: _____ SECONDARY CONTACT EMAIL			
Do you authorize the secondary contact listed to make medical decisions, <u>including lifesaving and financial decisions</u> , regarding your pet in the event we are unable to reach you? <input type="checkbox"/> Yes <input type="checkbox"/> 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 must note referring client on New Client & Patient Registration form 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 #2	Pet #3	Pet #4
Pet Name: _____	Pet Name: _____	Pet Name: _____	Pet Name: _____
Species: <input type="checkbox"/> Feline <input type="checkbox"/> Canine	Species: <input type="checkbox"/> Feline <input type="checkbox"/> Canine	Species: <input type="checkbox"/> Feline <input type="checkbox"/> Canine	Species: <input type="checkbox"/> Feline <input type="checkbox"/> Canine
Breed: _____	Breed: _____	Breed: _____	Breed: _____
Color: _____	Color: _____	Color: _____	Color: _____
DOB: _____	DOB: _____	DOB: _____	DOB: _____
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Spayed/Neutered? <input type="checkbox"/> Yes <input type="checkbox"/> No	Spayed/Neutered? <input type="checkbox"/> Yes <input type="checkbox"/> No	Spayed/Neutered? <input type="checkbox"/> Yes <input type="checkbox"/> No	Spayed/Neutered? <input type="checkbox"/> Yes <input type="checkbox"/> No
Microchipped: <input type="checkbox"/> Yes <input type="checkbox"/> No	Microchipped: <input type="checkbox"/> Yes <input type="checkbox"/> No	Microchipped: <input type="checkbox"/> Yes <input type="checkbox"/> No	Microchipped: <input type="checkbox"/> Yes <input type="checkbox"/> No
Any Known Allergies: _____	Any Known Allergies: _____	Any Known Allergies: _____	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 utmost 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:
(Please Circle one)

Owner Agent Good Samaritan

Signature of Spouse (if applicable)