

St. Louis Cat Clinic, Inc.
Client/Patient Registration
Welcome! Thank you for giving us the opportunity to care for your pet.
PLEASE COMPLETE ALL INFORMATION.

Owner's Name: (Mr./Ms./Mrs./Miss) _____

Address: _____ City: _____ State: _____ ZIP _____

Telephone: Home _____ Cell _____ Work _____

Occupation: _____ Employer: _____ Driver's License _____

Secondary Owner: _____

Telephone: Home _____ Cell _____ Work _____

Occupation: _____ Employer: _____ Driver's License # _____

Pet's Name: _____ Gender: _____ Spayed/Neutered? Yes No

Age: _____ Breed: _____ Color: _____ Markings _____

VACCINATION & MEDICAL HISTORY: Please give dates of most recent services

Distemper/Respiratory: 1yr or 3yr? Date: _____ Rabies: 1yr or 3yr? Date: _____

FIP Vaccine: _____ Feline Leukemia Vaccine: _____ FIV Vaccine: _____

Feline Leukemia/FIV Test: Pos or Neg? Date: _____ Fecal Check: Pos or Neg? Date: _____

Current Diet: _____ Current Medications: _____

Previous major medical/surgical problems & dates: _____

So that we may serve you better, please circle the letter that best describes your situation:

- | | |
|---|---|
| 1. A) My pet is a member of my family. B) I feel my pet is just a pet. C) I want a healthy pet, but I don't need explanations. | 3. A) I desire detailed explanations from the doctor B) I need only a summary of the problems & treatments. |
| 2. A) I want the very best medical care for my pet. B) I want good care but concerned about cost. C) I want only the services I request | 4. A) My pet stays indoors only. B) My pet spends time both indoors and outdoors C) My pet stays outdoors only. |

If you have used a veterinary clinic before and were not satisfied, please provide a brief description so we can work to avoid the same problems: _____

How did you hear about our clinic: Drove by/Saw sign _____ Internet site: _____ Newspaper Ad _____

Word of mouth (Who may we thank?): _____ Other _____

Reason for today's visit? _____

PAYMENT IS EXPECTED UPON COMPLETION OF SERVICES.

For your convenience, we accept Cash, Check, Visa, MasterCard, Discover, and the Citibank Health Card.

I agree to pay any additional charges related to the cost of collection (including, but not limited to, collection agency fees, reasonable attorney fees, and court costs) in the event I would fail to pay my bill.

Owner/Owner's Agent Signature: _____ Date: _____