



HASTINGS
VETERINARY
HOSPITAL

NEW PATIENT | REGISTRATION FORM

Owner Name*:

Spouse/Partner/Alternate Guardian*:

Address*:

City*:

Province*:

Postal Code*

Primary Phone* ()

Secondary Phone ()

Email Address*

* Your email will be used for appointment, medical, and vaccine reminders, as well as newsletters.

Accept Decline

Pet's Name*

Date of Birth:

Canine Feline Rabbit

Breed*

Sex: Male Neutered Male Female Spayed Female

Date/Type of last vaccine*

Is your pet insured?

Yes Name of Insurance Company:

If not, would you be interested in a free insurance trial if pet is eligible?

Yes No

Previous Vet:

How did you hear of about us?

Authorization

I hereby authorize the veterinarian to examine, prescribe for or treat the above described pet(s). I assume responsibility for all charges incurred in the care of these animals, I understand that these charges must be paid at the time of release and that deposit may be required for surgical treatment.

Accept Decline

DATE: