



# LONDON VETERINARY CLINIC

796 SOUTH LAUREL ROAD - LONDON, KY 40744  
(606) 878-6965

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Thank you for giving us the opportunity to care for your pet. We'll be happy to answer any questions you have about your pet's health. To insure the best care possible, please take the time to fill in this form completely. Thank you!

## REGISTRATION

Today's Date: \_\_\_\_\_

Owner: \_\_\_\_\_ (D.L.#) \_\_\_\_\_

Spouse/ Partner: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email : \_\_\_\_\_

WE WILL BE SENDING TEXT AND EMAIL REMINDERS.  
IF YOU WOULD LIKE TO GET A TEXT OR EMAIL FOR REMINDERS PLEASE CHECK BOXES BELOW

TEXT: YES \_\_\_\_\_ NO \_\_\_\_\_ EMAIL: YES \_\_\_\_\_ NO \_\_\_\_\_

How did you become aware of our hospital?  Yellow pages  Sign  Other  Recommendation

If Personal Recommendation, Who may we thank? \_\_\_\_\_

## PET HEALTH INFORMATION

Name of Pet: \_\_\_\_\_  Dog  Cat  Other: \_\_\_\_\_

Breed: \_\_\_\_\_ Color: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Male  Neutered -or-  Female  Spayed Approximate Weight: \_\_\_\_\_

Vaccination History: (Date and Type of Last Vaccinations ) \_\_\_\_\_

Date of Last Rabies Vaccination: \_\_\_\_\_ Received at: \_\_\_\_\_

Reason for Today's Visit: \_\_\_\_\_

## AUTHORIZATION

I hereby authorize the Veterinarian to examine, prescribe for, or treat for the above pet. I assure responsibility for all charges incurred in the care of this animal. I also understand that full payment is required upon rendering of services. Deposits are required on major medical/surgical cases, trauma cases, and emergency work when hospitalization is required. I agree to pay any costs and charges necessary for the collection of any amount not paid when due.

Signature of Owner: \_\_\_\_\_ Date: \_\_\_\_\_

We do NOT carry open accounts and hope the below alternatives are convenient for you:

- Cash  Check  Credit Card  Care Credit