

Registration Form

**** Please fill out separate form for each dog in household****

Today's Date: _____

Client Information

Owner First Name: _____ Owner Last Name: _____

Spouse Or Partner Name (If applicable): _____

Address: _____

City: _____ Zip/PC: _____

Phone: _____ Cell Phone: _____

Email: _____

Best contact hours: _____

Alternate person who can be responsible for the dog: _____

Were you referral by someone? Yes No Name of the person: _____

Pet Information

Dog Name: _____

Dog Age & Birth Date: _____

Breed: _____

Weight (lbs) : _____

Check one: Male Female

Check one: Spayed Neutered Unaltered

Valid Tag or License #: _____

Microchip Number: _____

Pet Health - *Please attach a photocopy of immunization record*

Dog has received complete immunizations for (check all):

DHLPP Bordatella (Kennel Cough) Rabies

Name and phone number of Vet: _____

Clinic Name: _____

Medical Conditions: _____

Allergies: _____

Has had flea/tick prevention: Yes, what kind: _____ No