South Miami ANIMAL CLINIC
6100 South Dixie Highway, South Miami, FL 33143
305.667.7238 | fax 305.663.9984 | contact@petpaws.net
SouthMiamiAnimalClinic.com

CLIENT REGISTRATION FORM

Please check one: **Current Client** _____ **New Client** _____

Name _____
Last *First* *Middle Initial*

Address _____
Street *Apt #* *City* *State* *Zip Code*

Best Phone Contact #_____ **Cell Phone**_____

E-Mail Address_____

Spouse or Co-Owner's Name_____

Emergency Phone #_____

How do you wish to receive reminders? Please choose ONE: Email ( ) Phone ( ) Postcard ( )

PET #1

Name_____
Birth Date_____
Species: DOG ( ) CAT ( ) Other:_____
Breed_____ **Sex**_____
Color _____
Neutered or Spayed _____ **Date**_____
Date of Last Vaccination_____
Last Rabies Vaccination_____
Where Shots Obtained_____
Any Long-Term Problems_____
_____
Current Medications, if any_____
Reason for Visit_____

PET #2

Name_____
Birth Date_____
Species: DOG ( ) CAT ( ) Other_____
Breed_____ **Sex**_____
Color_____
Neutered or Spayed _____ **Date**_____
Date of Last Vaccination_____
Last Rabies Vaccination_____
Where Shots Obtained_____
Any Long-Term Problems_____
_____
Current Medications, if any_____
Reason for Visit_____

List names and types of any other pets you may own: _____

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 this animal. I also understand that these charges will be paid at the time of release, and that a deposit may be required.

Signature of Owner or Agent_____**Date**_____