

Mountainview Veterinary Hospital

101 US Highway 46 West

Rockaway, NJ 07866

Phone: 973-983-0500 Fax: 973-983-0588

CLIENT REGISTRATION

Name: _____
Last First Middle

Address: _____
Street number and name City State Zip Code

Driver's License or I. D. Card Number: _____ Expiration date: _____

Email: _____ please mark if you would like to receive reminders via email ()

Phone: _____ Work: _____ Cell: _____

Alternate Contact: _____
Name Phone

How did you hear about us: Internet () sign () newspaper ()

Referred by someone () please give us their name so we may thank them _____

PATIENT REGISTRATION

Pet's Name: _____ Breed: _____

Birthdate (approximate if unknown): _____ [] Male [] Neutered [] Female [] Spayed

[] Dog [] Cat [] Bird [] Rabbit [] Reptile [] Rodent [] Other _____

Color/Markings: _____ Identification: _____

PROFESSIONAL FEES ARE TO BE PAID AT THE TIME SERVICES ARE PERFORMED

- In admitting my pet(s) for diagnostics, treatment, or surgery, I authorize the veterinarians of **Mountainview Veterinary Hospital**, and their support staff, to administer such treatment and/or perform such diagnostic or surgical procedures as deemed necessary.
- It is understood that an estimate of charges will be given for services. No guarantee or assurance can be made as to the results that may be obtained.
- Further, I understand that a deposit of 50% is required before services are performed and I assume full financial responsibility for all charges incurred by my pet. I realize that these charges may exceed a given estimate if complications arise. I understand that I will be contacted prior to treatment, if possible, should complications occur.

Signature: _____

Date: _____