Mountainview Veterinary Hosptial

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:**_____