



Skyview Veterinary Hospital  
 1632 Gleneagles Blvd.  
 (406) 256-3511 [www.yellowstonevalleyvet.com](http://www.yellowstonevalleyvet.com)  
 Todd McLane, DVM



## New Client Registration Information

Account #: \_\_\_\_\_

### OWNER INFORMATION

Date: \_\_\_\_\_  
 Owner: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_  
 Dr Lic#: \_\_\_\_\_  
 Senior citizen: Y / N      Active Military: Y / N  
 Email address: **please write clearly**

Would you like to be contacted by e-mail? Y / N

Employer's name: \_\_\_\_\_  
 Spouse's name: \_\_\_\_\_

Emergency Contact Info (other than yourself): Name: \_\_\_\_\_  
 Phone#: \_\_\_\_\_

How did you hear about us?

- Yellow pages
- Radio
- Direct Mailer
- Referring Vet: \_\_\_\_\_
- Exotic Pets
- Help for Homeless Pets
- Location
- Internet/Facebook
- Word of Mouth: name: \_\_\_\_\_

All fees are due when services are rendered. Please indicate your preferred method of payment:  
 Cash     Check     CreditCard     Carecredit

### PET(S) INFORMATION

Pet name: \_\_\_\_\_  
 \_\_\_ Dog \_\_\_ Cat \_\_\_ Other (specify) \_\_\_\_\_  
 Breed: \_\_\_\_\_  
 Color: \_\_\_\_\_  
 Birth Date and/or Age: \_\_\_\_\_  
 Sex: \_\_\_ M \_\_\_ F Spayed/Neutered? Y / N  
 Vaccination history  
 Last Vaccine date: \_\_\_\_\_  
 Pet's current medications: \_\_\_\_\_  
 Diet: \_\_\_\_\_  
 Previous Veterinarian: \_\_\_\_\_

Pet name: \_\_\_\_\_  
 \_\_\_ Dog \_\_\_ Cat \_\_\_ Other (specify) \_\_\_\_\_  
 Breed: \_\_\_\_\_  
 Color: \_\_\_\_\_  
 Birth Date and/or Age: \_\_\_\_\_  
 Sex: \_\_\_ M \_\_\_ F Spayed/Neutered? Y / N  
 Vaccination history  
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 Pet's current medications: \_\_\_\_\_  
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 Breed: \_\_\_\_\_  
 Color: \_\_\_\_\_  
 Birth Date and/or Age: \_\_\_\_\_  
 Sex: \_\_\_ M \_\_\_ F Spayed/Neutered? Y / N  
 Vaccination history  
 Last Vaccine date: \_\_\_\_\_  
 Pet's current medications: \_\_\_\_\_  
 Diet: \_\_\_\_\_  
 Previous Veterinarian: \_\_\_\_\_

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet.  
 I assume full 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.

Signature of owner (agent): \_\_\_\_\_

***Thank you for choosing Skyview Veterinary Hospital***