



# Cats Exclusive Veterinary Clinic

6350 W. Atlantic Blvd.

Margate, FL 33063

954 975-8349 ~ Fax: 954 973-3939

## WELCOME

Thank you for giving us the opportunity to care for your pet. We'll be happy to answer any questions you have about your pet's health. To ensure the best care possible, fill out the forms provided completely. Thank you!

### NEW CLIENT REGISTRATION

Your Name \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Street Address \_\_\_\_\_

BEST PHONE # to reach you today \_\_\_\_\_

City, State, Zip \_\_\_\_\_

e-mail address \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Would you like to join our mailing list? Yes \_\_\_ No \_\_\_

Do you have Pet Insurance? \_\_\_\_\_

By e-mail? Yes \_\_\_ No \_\_\_

#### ➔ PLEASE ANSWER below questions concerning your pet(s)' visit today:

Name Pet: _____	Name Pet: _____	Name Pet: _____
Age (or est. if not sure): _____	Age (or est. if not sure): _____	Age (or est. if not sure): _____
Sex: Male Female Neutered/Spayed? Yes No	Sex: Male Female Neutered/Spayed? Yes No	Sex: Male Female Neutered/Spayed? Yes No
Color / Markings: _____ Longhair? Shorthair?	Color / Markings: _____ Longhair? Shorthair?	Color /Markings: _____ Longhair? Shorthair?
Any Vet care in past 12 mos.? If so, where?	Any Vet care in past 12 mos.? If so, where?	Any Vet care in past 12 mos.? If so, where?

#### Please sign Authorization for General Care and/or Surgical Treatment:

I hereby authorize the Veterinarian to examine, prescribe for, and/or treat my pet(s). I assume responsibility for all charges incurred for the care of my pet(s), and that these charges are to be paid at the time of release. I also understand that a deposit may be required if surgical treatment or extended hospitalization is necessary for the welfare of my pet.

Signed \_\_\_\_\_ Date: \_\_\_\_\_