Welcome to Oakview!

Please spend a few moments filling out this form.

CLIENT REGISTRATION FORM

DATE:_____ CLIENT NUMBER:_____

OWNER'S NAME:_____

CO-OWNER / SPOUSE'S NAME:_____

ADDRESS:_____ CITY:_____

STATE:_____ ZIP:_____ E-MAIL ADDRESS:_____

HOME PHONE:_____ CELL PHONE: _____

WORK PHONE:_____ MAY WE CONTACT YOU AT WORK? ☐ YES ☐ NO

OCCUPATION:_____ EMPLOYERS NAME:_____

HOW DID YOUR HEAR ABOUT OUR HOSPITAL? (please check all that apply)

☐ NEWSPAPER ☐ RADIO ☐ TELEVISION

☐ INTERNET ☐ YELLOW PAGES ☐ HOSPITAL SIGN

☐ PROFESSIONAL REFERRAL ☐ FRIEND / RELATIVE REFERRAL

☐ IF REFERRAL - WHOM CAN WE THANK?

_____

PREVIOUS VETERINARY HOSPITAL_____

MAY WE REQUEST YOUR RECORDS FROM THEIR OFFICE? ☐ YES ☐ NO

Our objective as a hospital is to provide you and your animal family with the best possible veterinary care, ***thank you*** *for selecting us to care for your companions!*

Our staff will gladly prepare a written estimate of fees at your request. Please ask our staff if you have any questions regarding your pet's health care, our fees or payment procedures.

● ● ● **All fees must be paid in full at the time service is provided.** ● ● ●

We accept the following forms of payment:

Cash **Check** (valid drivers license required) **MasterCard** or **Visa** **CareCredit**

_____ _____

Signature of person responsible for payment Date