

Cave Spring Animal Hospital

19 Alabama Street
Cave Spring, Georgia 30124
Telephone: 706-381-2500

*The Intent of this veterinary group is to provide quality care for your pet.
If you have any questions concerning fees or services, please ask.*

Client Registration

Owners Name _____ Spouse/ Other _____

Address _____ City _____ State/ Zip _____

Home Phone # _____ Other Phone # _____

E-Mail Address _____

Employer's Name, Address, and Phone # _____

How did you hear about our clinic? _____

Social Security # _____

Personal Drivers License # _____ State _____ Expiration Date _____

***** Payment is due when services are rendered***
Please list Social Security # or Drivers License ONLY if paying by check**

What is your preferred method of payment? Cash___ Check___ Credit Card___

*****Please have proper identification available if you plan on using a check as your payment*****

Pet History

Name of Pet(s) _____ Dog _____ Cat _____ Other (specify) _____

Please list any chronic illnesses that your pet may have: _____

Breed _____ Color _____ Estimated Age _____

Male _____ Neutered _____ Female _____ Spayed _____

If you do not have any records from a previous veterinarian, please list the name of the clinic or doctor so we may have the records sent to us _____

I hereby authorize the veterinarian to examine, prescribe for, vaccinate, and or treat the above-described animal. I understand that my animal must be current with all vaccinations required by this facility. I assume 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 and that a deposit may be required for surgical treatment.

Signature _____ Date _____