



Elizabeth Audibert, DVM  
 19412 Harrison Ave.  
 Covington, LA 70433

## CLIENT INFORMATION / PET REGISTRATION

OWNER INFORMATION	
Name(s):	Address:
Primary Phone: Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/>	Secondary Phone: Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/>
May we send you text messages (pet updates, reminders) and/or pictures of your pet while in our care? (carrier rates may apply) Yes <input type="checkbox"/> No <input type="checkbox"/>	
Drivers License #:	Social Security # (for check writing privileges):
Email:	Employer Name and Phone:
How did you hear about our hospital? Internet <input type="checkbox"/> Social Media <input type="checkbox"/> Drive-by <input type="checkbox"/> Other <input type="checkbox"/> _____ Friend <input type="checkbox"/> If so, whom may we thank _____	
Preferred method for receiving reminders: Email <input type="checkbox"/> Postal Mail <input type="checkbox"/>	

PET INFORMATION									
Name	Dog or Cat	Breed	Date of Birth/ Age	Male or Female	Color/ Markings	Spayed/ Neutered Yes or No	Last Vaccine Date	Current Heartworm/ Flea Medications	Micro-chip

Please list an allergies, illnesses, current medications, vaccine reactions, and medical history that my help us in caring for yor pet \_\_\_\_\_

I authorize the use of my pet's first name, photograph, video and/or clinical information (including medical condition, treatment and prognosis) on Three Rivers Animal Hospital's website, social media, news media, and/or informational pamphlets. Yes  No  Initial \_\_\_\_\_

I, the undersigned, hereby authorize the staff of Three Rivers Animal Hospital to perform examinations, diagnostics, prescribe for, and treat my pet. PAYMENT IS DUE IN FULL AT THE TIME SERVICES ARE RENDERED. I understand that if I do not pay this account as agreed, the account is subject to costs of collection and attorney fees. All NSF checks will be charged a \$35.00 fee. I assume responsibility for all charges incurred for the care of my animal(s). I understand these charges must be paid at time of release and deposits may be required for surgical treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_