AUCKLAND VETERINARY DENTISTRY AND ORAL SURGERY

NEW CLIENT REGISTRATION FORM

CLIENT DETAILS	**PATIENT DETAILS**
Name:	Name:
Address:	Breed:
	Age/D.O.B.:
Phone:	Sex:
Mobile:	Desexed: Y N (please circle)
Email Address:	Colour:

REFERRING VETERINARIAN DETAILS

Veterinarian Name:

Veterinary Clinic Name:

Phone (s):

REASON FOR REFERRAL ______________________________

OTHER INFORMATION

Current Medication(s):

Current Diet:

Do you brush your pet's teeth? Y N (please circle)
If yes, how often? ____________________

- Please note that by signing below you are acknowledging that you will assume responsibility for all charges incurred in the care of this pet. I understand that full payment, in the form of cash, cheque, eftpos or credit card, is to be made at the time of consultation or upon collecting your pet from our hospital.

- I agree to return to my usual veterinarian for all other healthcare needs for my pet and agree that I will not return to Auckland Veterinary Dentistry and Oral Surgery or Kohimarama Veterinary Clinic.

Signature ____________________ **Date** ____________________

Email: reception@aucklandvetdentist.co.nz

Fax: (09) 528 9144

Phone: (09) 521 1457