



New Client Registration Form

Client/Owner Name: _____ Spouse/Co-Owner Name: _____

Home Address: _____ Apt Number: _____

City, State, Zip Code: _____

Home Tel Number: _____ Cell Number: _____

Work Number: _____ Emergency Number: _____

Email Address: _____

Pet's Name: _____ Breed: _____

Age: _____ Weight (lbs): _____ Color: _____ Species: (dog or cat) _____

Circle One Male Female

Circle One Intact or Neutered Intact or Spayed

Primary Veterinarian – Practice Name: _____

Veterinarian Name: _____ Business Phone Number: _____

Address: _____ City, State, Zip Code: _____

I hereby authorize the Veterinary Surgical Center of Long Island ("VSCLI") to examine the above pet. I assume responsibility for all charges incurred in the care and examination of this animal. I understand that a deposit will be required for all procedures and that all charges are to be paid in full upon completion of services rendered.

Client/Owner Name (Print Name)

Client/Owner Signature

Date