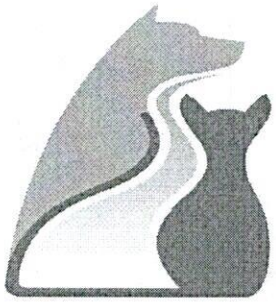

TCHEFUNCTE ANIMAL HOSPITAL

216 HIGHWAY 21 - MADISONVILLE, LA 70447 985.845.7484

NEW CLIENT REGISTRATION

Today's Date: _____
Driver's License or I. D. Card Number: _____ Exp.date:_____

Name:_____
Last First MI

Address:_____
Street number and name City State Zip Code

HOW DID YOU HEAR ABOUT US?_____

WHOM MAY WE THANK FOR THE REFERRAL?_____

e-mail: _____
(please include if you would like to receive reminders, etc. via email)

Telephone Numbers (please include area code):

Cell:(_____)_____-_____ Home:(_____)_____-_____ Work:(_____)_____-_____

Alternate Contact: _____
Name Phone

PROFESSIONAL FEES ARE TO BE PAID AT THE TIME SERVICES ARE PERFORMED

- **In admitting my pet(s) for diagnostics, treatment, or surgery, I authorize the veterinarians of Tchefuncte Animal Hospital, LLC, and their support staff, to administer such treatment and/or perform such diagnostic or surgical procedures as deemed necessary.**
- **It is understood that an estimate of charges will be given for services. No guarantee or assurance can be made as to the results that may be obtained.**
- **Further, I assume full financial responsibility for all charges incurred by my pet. I realize that these charges may exceed a given estimate if complications arise. I understand that I will be contacted prior to treatment, if possible, should complications occur. A deposit may be required. *All professional fees are due at time of services rendered.***
- **Payment is due when services are rendered. *We do not file pet insurance claims.* We will give you the necessary paperwork for you to be reimbursed for charges. *We do not bill for services.***

Signature: _____ Date: _____

Be sure to visit www.tchefuncteanimalhospital.com or find us on Facebook and Instagram!

Tchefuncte Animal Hospital

INDIVIDUAL PATIENT REGISTRATION

Preferred Doctor (Circle One)
NONE Dr. Moores Dr. Ferrara Dr. Brown

Species: (Circle One)
DOG CAT OTHER_____

Pet Information:

Patient Name:_____ Male/Female Neutered/Spayed

Breed:_____ Color:_____

Birth date or Approximate Age_____ Microchip Y/N #_____

Company_____

Where was the last set of Vaccinations Given?

Clinic Name_____Dr._____Phone_____

Client Name (first and last)_____

Patient Medical History

_____
_____
_____

Current Medications:

Medication_____Instructions_____
Medication_____Instructions_____
Medication_____Instructions_____

Special Diet:_____**Allergies**_____

Heartworm and/or Flea Prevention Y/N

Product Name_____Last Given_____