REVIEWED BY _____

Wood River Animal Hospital

Leah K. Fischer DVM
28 Kingstown Road Wyoming, RI 02898
401-539-1199
www.woodriveranimalhospitalinc.com

2025 New Client Registration

Date: _____

Owner's Name: _____Spouse/other: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Residence Address (if different):_____

Primary Contact Name: _____ Primary Contact Number: _____

Secondary Contact Name: _____ Secondary Contact Number: _____

Employer's Name: _____ Work Number: _____

E-mail Address:_____

Do we have permission to photograph your pets for social media purposes? (Circle): YES/NO

Do you have a preferred doctor at the practice? (Circle) Dr: Fischer Schuelke Kelley Provensal Boy

In case of an emergency and we cannot contact you: PLEASE CALL:

NAME: _____RELATIONSHIP: _____ PHONE:_____

How did you hear about us?:

_____

Please list the names & type of any other animals that you own:

_____

PLEASE TURN OVER AND COMPLETE

PET INFORMATION

#1 Pet's Name: _____Date of Birth: _____

Species: _____Breed: _____ Color: _____

Male: _____Neutered: _____ Female: _____ Spayed: _____

#2 Pet's Name: _____ Date of Birth: _____

Species: _____ Breed: _____ Color: _____

Male: _____Neutered: _____ Female: _____ Spayed: _____

Previous Veterinarian(s) Name/ Clinic:

_____

Pertinent Medical History:

_____

_____

_____

Do we need to be aware of any special needs or accommodations for you or your pet(s)?

_____

NOTICE REGARDING RECORDED COMMUNICATIONS

To enhance the accuracy of medical documentation and support the continued improvement of patient care, Wood River Animal Hospital may record verbal communications that occur in person or by phone. These recordings are used exclusively for the purposes of transcribing veterinary medical records and improving clinical documentation and care quality. All recordings and resulting transcripts are treated with the same confidentiality and security standards as your pet's medical records and are never used for marketing, promotional, or non-clinical purposes. If you **do not consent to being recorded**, please notify a staff member prior to or at the time of your interaction so that recording can be disabled for your visit or call.

FINANCIAL/BEHAVIORAL CONTRACT

I assume responsibility for all charges incurred in the care of this or any animal I own. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment or hospitalization. Any products, medications, food, etc., will be paid for in full upon time of purchase. I also understand that unpaid balances will incur billing and finance charges after 30 days by a periodic rate of 1% per month, with a minimum charge of $4.00. I understand that I will also be responsible for any missed fees that may be invoiced after the time of release. If you pay by check, a valid driver's license or picture identification is required. At Wood River Animal Hospital, we're committed to providing a safe and healing space to make life better for our patients. We require a respectful and supportive environment for our patients and for our team at all times. **My signature below indicates that I have read, understand, and have agreed to the above Financial & Behavioral Contracts.**

Owner Printed Name: _____Owner Signature:_____Date: _____