



CLIENT REGISTRATION

Primary Guardian's Name

Address _____ City _____ Zip _____
Home Phone # () _____ Work # () _____ Cell # () _____
Email Address (all WOOF correspondence is via e-mail) _____

Secondary Guardian's Name

Address _____ City _____ Zip _____
Home Phone # () _____ Work # () _____ Cell # () _____

Other persons authorized to drop-off and /or pick-up my Dog(s):

Who is your local Veterinarian Hospital? (This is where we will attempt to take your dog to seek medical attention if needed):

Veterinarian _____ Phone # _____

Please name a local friend or family member we can contact in case of an Emergency:

Name _____ Phone Number _____

DOG INFORMATION

Dog 1 Name

Breed _____ Color _____

Sex: Male _____ Female _____ My Dog is Neutered / Spayed (required at 4+months): Yes _____ No _____

Weight _____ lbs Age: _____ Special Needs? _____

VACCINATIONS: Please have your vet fax this information to us at 925-855-9663 or provide a written receipt to us

(For WOOF use only) Bordetella _____ Distemper _____ Rabies _____

Dog 2 Name

Breed _____ Color _____

Sex: Male _____ Female _____ My Dog is Neutered / Spayed (required at 4+months): Yes _____ No _____

Weight _____ lbs Age: _____ Special Needs? _____

VACCINATIONS: Please have your vet fax this information to us at 925-855-9663 or provide a written receipt to us

(For WOOF use only) Bordetella _____ Distemper _____ Rabies _____

HOW DID YOU HEAR ABOUT WOOF?

(WOOF USE ONLY) Trial day: _____ Outcome: _____ Boarding Dates To Book: _____
Daycare

Medical Release Filed _____ Account Flagged as New client _____ Boarding Dates Booked _____

Data Entry Completed on: _____ By _____