Registration

Welcome to our Hospital

Advance payment in full [FOR FIRST VISIT] required BEFORE Starting Any Service.

You and your pets information will be held confidential. Please complete and answer all questions. No service provided without photo I.D. "Drivers License" and credit card copy to be on file.

Information provided will help us to support your needs and pets needs today and in the future.

Are you the owner who is responsible for all financial, decision and needs for your pets. Yes___ No___.
If no what is the name of the pets owner?____
Pet owner who is responsible and (adult 21 years or older) has to complete this registation.

Owners full name____________________________ Co/owners full name ________________
Home Address__________________________
City____________________State____Zip________Own______or Rent______
How long on current address______________

Telephone

Home(   )_________________ Cell(   )_________________ Work(   )_________________
Emergency Contact and Name(   )____________________(If we can not reach you)
E-mail____________________ Work(   )_________________ Employer name ______________
Employer Address____________________ City_____________ State________ Zip______________
Unemployed_______Retired ________Are you a Senior Citizen (60 or over) Yes____ No ____

Payment in full are expected when service rendered some procedure and services require full payment in advance or deposit. Billing, charges, easy pay and financial arrangment provided by others. We provide many payment options for your convience. (payment by check verified by telecheck) $49.00 Fee for all returned checks.

What is the convient method of payment you will be using most of the time?
___Cash ___Check ___Credit Card
If paying by credit card MC, Visa ,AE or Discover (circle one)
Card #____
Name appear on card____Exp. Date
Last three digits on back_______________Billing address for the card____________

*__Care Credit__ for your peace of mind-we will help get you started for approved credit. [$300.00 or more recieve no interest for 90 days.]

Estimate: We will provide you with written estimate in advance and you to decide what level of health care you want for your pets. (Please ask for an estimate before service is provided.)

Hospital Tour: If you would like a tour of the hospital please let us know.

PLEASE COMPLETE OTHER SIDE.

Pet Registration

Pet Name ________________ Breed ________________

Species: Dog Cat Other ________ (Circle one)

Sex ______ Spay / Neuter (Circle one) Age ______

Color / Markings ________________________________

Please list all previous veterinary service.

[1] Name of clinic or hospital.
Vet name. ________________________________
Address ________________ City ________ State ________ Zip ________
Telephone# ________________ Date of last visit. ________________

[2] Name of clinic or hospital. ________________________________
Vet name ________________________________
Address ________________ City ________ State ________ Zip ________
Telephone# ________________ Date of last visit ________________

[3] Name of clinic or hospital. ________________________________
Vet name ________________________________
Address ________________ City ________ State ________ Zip ________
Telephone# ________________ Date of last visit ________________

To better serve you and your pets. Tell us what specific service we provide which attracted you to us.

Second Opinion ______ Location ______ AAHA Hospital ______ Boarding ______
Exotic Pets / fish Medicine ________ Hours ________

Did someone refer us to you? If so both of you will receive a $10.00 Gift Certificate for future Services.

Referral Name ________________________________
Address ________________________________ Telephone# ________________

PET OWNER NAME ________________________________
SIGNATURE ________________________________ **DATE** ________________