CAUTION ☐

CLIENT REGISTRATION FORM

CLIENT ID: PATIENT ID:

OWNER INFORMATION Email: @

Home Phone # Cell Phone # Date

Last Name First Name Spouse

Home Address Apt City Zip

Employer Name Work Phone # ext

PET INFORMATION

Species ☐ Dog ☐ Cat ☐ Bird ☐ Rabbit ☐ Guinea Pig ☐ Hamster ☐ Snake ☐ Lizard ☐ Turtle/Tortoise Other

Pet Name Breed Color

Sex: ☐ Male ☐ Neutered ☐ Female ☐ Spayed Date of Birth

Vaccination History Is this pet current? No ☐ Yes ☐ Date Vaccinated_____ Clinic _____

Canine Vaccines ☐ Distemper (DHP) ☐ Parvo ☐ Corona ☐ Bordetella ☐ Lyme ☐ Rabies

Feline Vaccines ☐ Distemper (FVRCP) ☐ Chlamydia ☐ Leukemia ☐ FIP ☐ FIV ☐ Rabies

Any Known Allergies? No ☐ Yes ☐ Is your pet on any medications? No ☐ Yes ☐

I/We understand that all services are to be paid in full at the time they are rendered. (Please Initial)

We accept cash, check (with appropriate identification), Visa, Mastercard, Discover and American Express.

*** <u>If you chose to pay by check, please read and complete the following:</u>**

- Check must be imprinted with your name, current address and phone number. Checks may not be post dated.
- Valid Driver's License Number _____ State of Issue_____ Exp. Date_____ DOB_____
- Major Credit Card Bank Name_____ Exp. Date_____

I hereby authorize American Animal Hospital to administer such treatment, surgery, or additional procedures as determined necessary on the basis of findings during examination. I understand I will be given an extimate for all recommended services <u>prior to rendering</u>. Exceptions are the regular office visit charge, and emergency (life saving) services, which will be rendered immediately, as determined by the Doctor. (Please intial)

I, the undersigned, agree as owner or agent, that in consideration of the services rendered to the above described patient, obligate myself to pay all fees incurred at the time patient is released. The undersigned certifies that he/she is at least eighteen (18) years of age and that he/she is the owner or the owner's agent of the above animal, and is duly authorized to execute the above and accept its terms. (Please initial)

I understand that a deposit equal to the minimum amount of the estimate will be required for all patients admitted to the hospital. (Please initial)

I agree to remove the patient, and pay all fees due, within threee (3) days of notification that the patient is to be discharged. If I fail to pick up the patient within three (3) days, I understand that I relinquish all claim to the said patient and it will be considered an abandoned animal. American Animal Hospital is free to make whatever decisions deemed appropriate for an abandoned animal. Abandonment of an animal does not release the undersigned from their obligation to pay fees for services rendered on patient, including charges for additional boarding and costs due to animal's abandonment.

All sales on prescriptions or products are final - No Returns. Fees for services are not refundable. No personnel are on the premises after clinic hours.

Signature of Owner/Authorized Agent_____

OFFICE USE ONLY

CLIENT ID: PATIENT ID:

RX DIET_____ MICROCHIP #_____

X-RAY #_____ 6 MONTH BORDETELLA _____