If you have Adobe Acrobat XI or higher, this form can be electronically signed and emailed to the hospital. Once the form is signed, you can click the "Send Form" button at the end of the form to submit. Adobe Acrobat can be downloaded **HERE**. If you can't sign and send electronically, please print, sign and bring with you to the hospital.

LeadER

Animal Specialty Hospital

Exceptional care, pure and simple, 24/7/365

Client Registration Form

Date: _____

Last Name:_____ First Name:_____ Spouse/Co-Owner: _____

Address: _____

City:_____ State:_____ Zip:_____

Phone Numbers: ◯ Home:_____ ◯ Work:_____ ◯ Cell:_____

Please check the primary contact number above.

Email Address: _____

Employer and Address: _____

Were you referred to our office by a veterinarian or their answering service? Yes_____ No_____ Receptionist _____

If yes:

Veterinarian/Clinic that referred you to us? _____

Who is your Primary Care Veterinarian? _____

Are there any other veterinarians/hospitals involved in this case?_____

If you were not referred by a veterinarian, how did you hear about us? _____

◯ internet ◯ friend ◯ phonebook ◯ drive by ◯ other – please fill in on line above

Reason for visit ? _____

PAYMENT POLICY

Emergency Examination Fee: $120.00

Full payment is required at the time services are rendered. A 50% deposit is required on all cases and emergency procedures where hospitalization is required.

Please indicate your choice of payment method: ◯ Cash ◯ Credit Card ◯ Care Credit

Drivers License #:_____ Exp. Date:_____

We will prepare a written estimate for services. We do not carry open accounts and hope the above alternatives are convenient for you. I agree to pay any costs and charges necessary for the collection of any amount not paid when due. I am aware that Animal Medical Center/Veterinary Specialists of South Florida/Animal Emergency and Critical Services of South Florida, in accordance with the American Veterinary Medical Association's code of professional ethics, will provide only such emergency treatment as they deem necessary and that my pet and all it's pertinent records will be sent back to the veterinarian that referred me as soon as practical. Under no circumstances will a client referred by another veterinarian be accepted as a regular client of Animal Medical Center of Cooper City.

I give permission to use my pet(s) images for marketing and advertising purposes. **Initial** your choice: YES_____ NO_____

_X_____Signature of Owner or Authorized Agent

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1ST PET INFORMATION

Name: _____

Species (Cat or Dog): _____

Breed: _____

Color: _____

Date of Birth: _____ If unknown, approximate age: _____

Sex: _____

Spayed / Neutered _____ Yes _____No

Is your pet up to date on vaccines? _____

How long have you owned your pet? _____

Please list prior illnesses, surgeries, allergies: _____

Is your pet currently on any medications? _____ Yes _____ No

If yes, names of medications and dosage: _____

2ND PET INFORMATION

Name: _____

Species (Cat or Dog): _____

Breed: _____

Color: _____

Date of Birth: _____ If unknown, approximate age: _____

Sex: _____

Spayed / Neutered _____Yes _____No

Is your pet up to date on vaccines? _____

How long have you owned your pet? _____

Please list prior illnesses, surgeries, allergies: _____

Is your pet currently on any medications? _____ Yes _____ No

If yes, names of medications and dosage: _____

SEND FORM