

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.



## 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:

What is the name and phone number of the *referring* clinic? \_\_\_\_\_

What is the name of the *referring* veterinarian? \_\_\_\_\_

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

a) internet b) friend c) phonebook d) drive by e) 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 its 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



**1<sup>ST</sup> 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: \_\_\_\_\_



**2<sup>ND</sup> 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**