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.

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: $135.00

Full payment is required at the time services are rendered. A 75% 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