

Client/Patient Registration

Thank you for giving us the opportunity to care for your pet.
Please complete ALL the information below.



Today's Date _____

Owner's Name: Last _____
First _____ Initial _____

Co-owner's Name: Last _____
First _____ Initial _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Best Time To Call _____

Work Phone _____ Best Time To Call _____

Emergency Phone _____ E-Mail _____

Cell Phone _____ Best Time To Call _____

Employer _____ Occupation _____

Who is responsible for this account? * _____

Address if other than owner(s) _____

Driver's License# (required)* _____ State* _____

Pet's Name _____ Birthdate _____ Sex _____

Dog

Cat Does your cat (cats) EVER have the opportunity to go outdoors? Yes _____ No _____

Other

Color _____ Breed _____ Has pet been spayed/neutered? _____

Please check which category best describes the human/animal bond you enjoy with your pet:

Family member Family pet Casual companion

Previous Doctor's Name/Location _____ May we obtain your pet's records? _____

Reason for transfer _____

What was the last kind of treatment? (exam, shot, etc.) _____

Reason For Visit _____

If primary reason for this and future visits is to board your pet(s) and you intend to continue with your current veterinarian for medical services please indicate: boarding services only? Yes _____ No _____

How did you learn of our hospital?

Print Yellow Pages On-Line Yellow Pages Recommendation by _____ Hospital Sign

Our Website www.FAHCT.com Internet Other: _____ Other _____

Please indicate how account will be paid: Cash Check Credit Card

I authorize Farmington Animal Hospital to administer treatment as is considered necessary. On my request the Hospital will provide me with a written estimate of fees. A deposit prior to treatment may be required depending on the nature and type of procedure. All balances are due in full at the time the patient is released. THIS HOSPITAL DOES NOT BILL. The returned check fee is \$25. Interest, at 1½% compound monthly and a \$5.00 monthly statement/billing fee will be added to any out-standing balance. If this account is submitted for collection, I/we will be responsible for all costs of collection including 15% to the collection agency, and a reasonable attorney's fee. If the court becomes involved, I will be responsible to pay any associated costs.

Owner's/Co-Owner's Signature* _____

Thank you!