

ADA ANIMAL HOSPITAL
CLIENT REGISTRATION FORM

CLIENT INFORMATION

LAST NAME _____ FIRST NAME _____

ADDRESS _____ ZIP _____ PRIMARY PHONE _____

CITY _____ STATE _____ WORK PHONE _____ OTHER PHONE _____

E-MAIL ADDRESS (for reminders): _____ EMPLOYER _____

HOW DID YOU HEAR ABOUT US? _____ YELLOWPAGES _____ DRIVE BY _____ WEB
_____ COUPON _____ PERSONAL REFERRAL (WHOM MAY WE THANK?) _____

SPOUSE _____ SPOUSE'S EMPLOYER _____

SPOUSE'S WRK PHONE _____ OTHER PHONE _____

PREVIOUS VET CLINIC _____ MAY WE REQUEST RECORDS? _____

PATIENT INFORMATION

PET'S
NAME _____

BREED _____

COLOR _____

MALE / FEMALE (Please circle)

INTACT: Yes No (Please circle)

BIRTH DATE _____

PATIENT INFORMATION

PET'S
NAME _____

BREED _____

COLOR _____

MALE / FEMALE (Please circle)

INTACT: Yes No (Please circle)

BIRTH DATE _____

PATIENT INFORMATION

PET'S
NAME _____

BREED _____

COLOR _____

MALE / FEMALE (Please circle)

INTACT: Yes No (Please circle)

BIRTH DATE _____

**PROFESSIONAL FEES ARE TO BE PAID AT THE TIME THEY ARE RENDERED.
WE DO NOT BILL.**

AUTHORIZATION FOR TREATMENT

THE FOLLOWING ARE TERMS AND CONDITION FOR TREATMENT AND RELEASE FOR ABOVE ANIMAL(S):

1. I authorize the Ada Animal Hospital to treat the above animal. I do hereby consent to all surgical and medical treatment necessary, as well as any dentistry and laboratory tests. Surgical risks, fees, and procedures (including anesthesia) applicable to this case should be explained to me. Questions are encouraged.
2. I understand that no guarantee of successful treatment is made.
3. I am aware that all treatment, laboratory and medication charges are in addition to the examination fee. I agree to pay all chares incurred at the time of my pet(s) release.
4. In the event of death of the pet(s), I will make suitable arrangements for the remains; I will be responsible for reasonable costs incurred.
5. In the event I fail to pick up the pet(s) from the clinic within seven (7) days for the date I am notified by phone or by mailing such notice to the address above, the Ada Animal Hospital is authorized to dispose of the pet(s). I will pay a reasonable fee for such services.
6. In the event my pet(s) records need be copied, sent or faxed to myself or another Veterinary Clinic; I authorize Ada Animal Hospital to do so.
7. I am the owner, or authorized agent, of the described pet(s) and have the authority to enter into this agreement and the terms thereof.

SIGNATURE OF OWNER OR AGENT _____ DATE _____

TERMS: Net cash, all accounts billed due and payable 1 month following date of service. A service charge of 2.00% monthly (24% annually) applied to all balances over 30 days. A billing charge of \$5.00 applied to all billed accounts.