

NEW PATIENT REGISTRATION

Your Name _____

SSN _____ Date of Birth _____

Drivers License _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Cell Phone #1 _____

Work Phone _____ Cell Phone #2 _____

*Email _____

*Please enroll me as a registered member of the hospital website: **Yes** No

As a registered member I will be able to:

I Check pets' vaccinations status I Request appointments/boarding I Purchase medication/food refills
I Make better decisions about pets' health & well-being I Discover ways to help your pet live a longer & healthier life I Inform if pet is lost/deceased I Notify of address change I

*Please subscribe me to the **FREE** Pet Living & Wellness Newsletter: **Yes** (choose topics) No

Dogs Cats Horses Birds Reptiles Rodents Dr/Member Announcements.

Please note: Your privacy is important to us.
All information received in all forms and through other communications is subject to our **Patient Privacy Policy**.

PET INFORMATION

Pet's Name _____ Age/DOB _____

Breed _____ Dog / Cat / Other _____

Male Female
 Male / Neuter Female / Spay

Pet's Name _____ Age/DOB _____

Breed _____ Dog / Cat / Other _____

Male Female
 Male / Neuter Female / Spay

Pet's Name _____ Age/DOB _____

Breed _____ Dog / Cat / Other _____

Male Female
 Male / Neuter Female / Spay

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Breed _____ Dog / Cat / Other _____

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Breed _____ Dog / Cat / Other _____

Male Female
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All payments are due at the time of services rendered.

We accept cash, checks, all major credit cards, & Care Credit which can be approved in as little as 10 minutes.

Method of payment: Cash | Credit Card # _____ Exp _____

I understand every effort will be made to achieve a successful outcome and to provide for all possible safety in hospital care and handling. I hereby authorize this hospital to receive, prescribe for, treat or perform surgery upon the pet(s) listed above. Furthermore, I agree to pay fees for all services rendered at the time the pet is discharged from the hospital or the service is otherwise terminated. I agree to pay for the reasonable costs of collection, attorney fees, and court costs in the event that collection efforts become necessary. I agree that the venue of this action will be in the county where the hospital is located. I understand that Veterinary service is provided during nighttime hours as necessary in the judgment of the Veterinarian in charge. Continuous presence of qualified personnel may not be provided.

By signing below I authorize the staff at Animal Hospital of Hallandale to Request and forward my pets' records and information as needed for medical or prescription purposes. I have read and understand the above statements and agree to all terms therein.

Signature _____ Date _____