Animal Hospital of Hallandale
904 West Hallandale Beach Blvd
Hallandale, FL 33009
Ph: 954-458-3040
www.animalhospitalofhallandale.com
Joe Barbosa D.V.M. | Javier Cepeda D.V.M.

Date: _____ E-mail_____

Owner Last, First: _____ Spouse: _____

Address: _____City: _____Apt #_____Zip_____

Home Phone #_____Cell Phone #_____

In case of an Emergency, Call: _____Phone #_____

Who may we thank for the Referral? _____

Is your pet up to date on vaccines? Y___ N___ Date of last vaccination_____

Pet(s) Information **Pet 1** **Pet 2** **Pet 3**

NAME/SPECIES			
BREED			
COLOR			
AGE/D.O. B			
MALE/FEMALE			
SPAYED OR NEUTERED			

Method of payment: (circle one) Cash > Debit > Credit > Care Credit >> NO CHECKS accepted

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.

Signature_____Date_____