Flagler Animal Hospital

130 Old Kings Road S.

Client Registration Information

Client Name: ______________________________ Spouse/Sig. Other name: _________________________

Mailing address: _____________________________ E-mail address:______________________________

City: ____________________________________ State: ________________ Zip: _________________

Home phone: _____________________________ Cell phone: _______________________________

Please provide your Drivers' License so that we may copy it for our files. DL#______________________

Is anyone else authorized to make decisions regarding your pet's health care that is not listed above?

____ yes ____ no Name of other individual(s) ____

Pet Information

Name: __________________________ Dog: _____ Cat: _____ Date of birth: ______ Sex: _________

Breed: __________________________Spayed/Neutered? ____________ Color:_________________

Allergies to food or medications? ☐ Yes ☐ No

ON medication(s)? ________ **Pet's Veterinarian:** ________________________________

Payment Information

<u>All services must paid in-full at time of visit.</u>

Emergency Examination Fee is due at check-in.

Please indicate your method of payment:

Visa _______ MasterCard ______ Discover_________ Care Credit_______ Cash______

PAYMENT POLICY

After the doctor on duty has examined your pet, an estimate of how much the treatment will cost will be provided to you. You will be required to provide payment on the lower range of the total estimated amount <u>BEFORE</u> any treatment can be started by the doctor.

AUTHORIZATION

I hereby authorize the veterinarian to treat my pet.

I assume responsibility for all charges incurred in the care of this animal. <u>I understand that the charges will be paid at the time of release and that a deposit will be required for treatment.</u> I also authorize FAH doctors to release my pet's medical record to 3rd parties (referring veterinarian) at my request.

Signature of owner ____ Date _______________

June 2017