SOQUEL CREEK ANIMAL HOSPITAL

Owner Registration Form:

Last Name: _____ First Name(s):_____

Street Address: _____ Zip: _____ City: _____

Mailing Address: _____ Zip: _____ City: _____

Phone: _____ Work: _____ Cell: _____

Email: _____ DOB: _____

Drivers License #: _____

Occupation: _____ Spouse/Significant Other's Name: _____ Phone: _____

How were you referred to our Hospital? _____

Pet Information:

Name: _____ Dog / Cat

Breed: _____ Color: _____

Birth Date: _____ *or* Approximate Age: _____

Gender: _____ Spayed: Yes / No Neutered: Yes / No

Last Veterinarian & Clinic Name: _____

Have you vaccinated anywhere else? _____

Chronic Medical Conditions: _____

Current Medication_____

Flea and Tick Prevention: _____ Heartworm Prevention: _____

What food do you feed your pet? _____

May we use your pets picture on our Facebook page? Yes / No

Please Read and Sign the Following Authorization for Treatment

I hereby authorize the staff of SCAH to render any treatment that is deemed necessary to my pet(s) health while in custody of the hospital. I understand that in the event of any unusual or emergency circumstances, the staff will make every attempt to contact me or my designated representative before, if time permits, proceeding with treatment. I understand that I will be financially responsible for all emergency procedures including those on the estimate of charges provided to me in person or over the telephone.

I also understand that ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.

Signature of client responsible for pet(s): _____ Date: _____