CLIENT REGISTRATION FORM

Please print neatly. Fill out the entire form completely and sign. Failure to do so may extend your wait or delay evaluation or treatment of your pet. Have you ever been to this hospital before? ❑ YES ❑ NO

INFORMATION ABOUT YOU

PRIMARY OWNER'S NAME: (Last) _____ (First) _____ (Middle) _____

SPOUSE'S/EMERGENCY CONTACT NAME: (Last) _____ (First) _____ (Middle) _____

ADDRESS: _____APT/SUITE #: _____

CITY: _____STATE: _____ ZIP CODE: _____

HOME PHONE: (_____) _____ WORK PHONE: (_____) _____CELL PHONE (_____) _____

SOCIAL SECURITY #: _____ D L #: _____STATE OF DL _____EXP.DATE _____/_____/_____

DATE OF BIRTH _____/_____/_____ E-MAIL ADDRESS: _____

E-MAIL ADDRESS: _____ SPOUSE'S/EMERGENCY CONTACT WORK PHONE# (_____) _____

EMPLOYER: _____ PHONE: (_____) _____EXT: _____

EMPLOYER ADDRESS: _____

REFFERED BY: ❑ INDIVIDUAL/SOMEONE WE MAY THANK?

_____

HOW DID YOU FIND US? ❑ FRIEND ❑ SIGN ❑ YELLOW PAGES ❑ WEBSITE ❑ INTERNET ❑ PET SHOP ❑ WALK-IN ❑ FLYER ❑ NEWSPAPER ❑ OTHER

INFORMATION ABOUT YOUR PET

PET'S NAME: _____ SPECIES: ❑ CANINE ❑ FELINE BREED: _____ COLOR(S): _____

DATE OF BIRTH: _____/_____/_____/ SEX: ❑ MALE ❑ FEMALE ❑ SPAYED ❑ NEUTERED LAST RABIES VACCINE: _____/_____/_____

IN THE LAST YEAR, HAS YOUR PET BEEN VACCINATED AGAINST: ANSWER ❑ YES ❑ NO ❑ UNKNOWN

BOTH	CATS	DOGS
❑ RABIES	❑ FELINE LEUKEMIA VIRUS (FELV)	❑ LEPTOSPIROSIS
❑ DISTEMPER	❑ FELINE IMMUNODEFICIENCY VIRUS (FIV)	❑ LIME DISEASE
❑ HEARTWORM PREVETION	❑ FELINE INFECTIOUS PERITONITIS (FIP)	❑ PARVOVIRUS

HAS YOUR PET EVER HAVE ADVERSE DRUG REACTION? ❑ YES ❑ NO IF YES, PLEASE EXPLAIN:

_____

PAYMENT TERMS: We accept Cash, Visa, MasterCard, Discover, Debit ATM Cards and Care Credit. Payment of the entire medical treatment plan is required on all patient admissions, and the balance, if any, is due upon patient discharge. I agree to make prompt and complete payment upon discharge of my pet(s).

PATIENT AGREEMENT: I/we hereby authorize Pulse Animal Medical Center, Inc., Cahuenga Pet Hospital and all assistants of its choice to administer any medical and/or surgical treatments/procedures as is considered therapeutically and/or diagnostically necessary. I further understand that no guaranty of successful treatment is made. I/we hereby release Pulse Animal Medical Center, Inc., Cahuenga Pet Hospital, and all its personnel or assistants, from any liability by any reason of any act hereinabove authorized. I assume full financial responsibility for all charges incurred for the care and treatment of my pet(s). I further understand that if I fail to pay the entire amount, a monthly service charge of 1.5% will be added to any unpaid balances over 30 days. If my account is turned over to a collection agency, I agree to pay 40% of the unpaid balance as collection fees in addition to the principle amount owed. I further agree to pay reasonable attorney fees and court costs arising out of any litigation concerning the collection of this account. I hereby authorize the collecting practice to obtain credit reports on me. I consent to release all above information to any collection agencies as may be deemed necessary by the management. I also understand that if I neglect to pick up the above animal within the time required by Sec.1834.5 and 1834.6 (14 days after it is due to be pick up) California Civil Code, shell be deemed abandoned by owner and will be disposed of according to Sec. 1834.5 of the California Civil Code. In doing so, I understand that this does not relieve me from my financial obligation.

I have read the foregoing and agree.

OWNER/AGENT: _____ DATE: ___/_____/_____/ TIME: _____STAFF NAME: _____