CLIENT REGISTRATION FORM

Thank you for giving us the opportunity to care for your pet. Please help us to better meet your needs by taking a few moment s to completely fill out this information sheet. PLEASE PRINT IN INK AND SIGN.

INFORMATION ABOUT YOU

PRIMARY OWNER'S NAME_____

ADDRESS _____APT/SUITE#_____

CITY_____STATE_____ZIP CODE_____COUNTY_____

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

SOCIAL SECURITY #:_____DL#: _____ STATE OF DL: _____

DATE OF BIRTH: _____ E-MAIL:_____

EMPLOYER: _____ PHONE: (_____) _____EXT:_____

EMPLOYER'S ADDRESS: _____

EMERGENCY CONTACT: _____RELATION:_____PHONE: (_____) _____

HOW DID YOU FIND US? FRIEND YELLOW PAGES WEBSITE INTERNET WALK-IN FLYER NEWSPAPER OTHER_____

INFORMATION ABOUT YOUR PET

PETS NAME:_____ DATE OF BIRTH/AGE:_____

SPECIES: _____ BREED: _____ COLOR: _____

SEX: MALE FEMALE SPAYED NEUTERED KNOWN ALLERGIES (FOOD, DRUG, ETC):_____

IS YOUR PET CURRENT ON VACCINES? _____ LAST VACCINATION DATE: _____

PRIMARY/PREVIOUS VETERINARIAN:_____

REASON FOR VISIT: _____

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

PATIENT AGREEMENT: I/we hereby authoriz e The Ark Animal Hospital, LLC 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 guarant y of successful treatment is made. I/we hereby release The Ark Animal Hospital, LLC 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 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.

MEDIA RELEASE AUTHORIZATION: I authorize The Ark Animal Hospital, LLC to use, reproduce, and/or publish photographs and/or video that may pertain to my pet —including my pet's image, likeness and/or sound without compensation. I understand that this material may be used in various publications, public affairs releases, recruitment materials, broadcast public service advertising (PSAs) or for other related endeavors. This material ma y also appear on The Ark Animal Hospital's Internet Web Page or its other social media sites. This author ization is continuous and may only be withdrawn by my specific rescission of this authorization. Consequently, The Ark Animal Hospital, LLC may publish materials, use my pets' name, photograph, and/or make reference to m y pet(s) in any manner that The Ark Animal Hospital, LLC deems appropriate in order to promote/publicize/educate service opportunities.
DECLINED _____ ACCEPTED_____

Owner or Responsible Party_____Date: _____