REGISTRATION FORM

Ada Animal Hospital
8250 W Victory Rd
Boise, ID 83709
(208)362-5329

CLIENT INFORMATION

LAST NAME_____FIRST NAME_____

ADDRESS_____ZIP_____PRIMARY PHONE _____

CITY_____STATE _____ WORK PHONE _____OTHER PHONE_____

E-MAIL ADDRESS (for reminders): _____EMPLOYER_____

HOW DID YOU HEAR ABOUT US? _____YELLOWPAGES_____DRIVE BY_____WEB _____
COUPON____ PERSONAL REFFERAL (WHOM MAY WE THANK?)_____

SPOUSE _____ SPOUSE'S WRK PHONE_____OTHER PHONE:_____

PATIENT INFORMATION

PET'S NAME_____

BREED_____

COLOR_____

MALE / FEMALE (Please circle)

NEUTERED: (Male): Yes No (Circle)

SPAYED: (Female): Yes No (Circle)

BIRTHDATE / AGE_____

PATIENT INFORMATION

PET'S NAME_____

BREED_____

COLOR _____

MALE / FEMALE (Please circle)

NEUTERED: (Male): Yes No (Circle)

SPAYED: (Female): Yes No (Circle)

BIRTHDATE / AGE_____

PATIENT INFORMATION

PET'S NAME_____

BREED_____

COLOR_____

MALE / FEMALE (Please circle)

NEUTERED: (Male): Yes No (Circle)

SPAYED: (Female): Yes No (Circle)

BIRTHDATE / AGE_____

PROFESSIONAL FEES ARE TO BE PAID AT THE TIME THEY ARE RENDERED.

WE DO NOT BILL.

AUTHORIZATION FOR TREATMENT

THE FOLLOWING ARE TERMS AND CONDITION FOR TREATMENT AND RELEASE FOR ABOVE ANIMAL(S):

1. I authorize the Ada Animal Hospital to treat the above animal. I do hereby consent to all surgical and medical treatment necessary, as well as any dentistry and laboratory tests. Surgical risks, fees, and procedures (including anesthesia) applicable to this case should be explained to me. Questions are encouraged.
2. I understand that no guarantee of successful treatment is made.
3. I am aware that all treatment, laboratory and medication charges are in addition to the examination fee. I agree to pay all chares incurred at the time of my pet(s) release.
4. In the event of death of the pet(s), I will make suitable arrangements for the remains; I will be responsible for reasonable costs incurred.
5. In the event I fail to pick up the pet(s) from the clinic within seven (7) days from the date I am notified by phone or by mailing such notice to the address above, it will be assumed the pet is abandoned and Ada Animal Hospital is hereby authorized to proceed as management deems best and/or necessary and I will be held responsible for any expenses incurred.
6. In the event my pet(s) records need be copied, sent or faxed to myself or another Veterinary Clinic; I authorize Ada Animal Hospital to do so.
7. I am the owner, or authorized agent, of the described pet(s) and have the authority to enter into this agreement and the terms thereof.

SIGNATURE OF OWNER OR AGENT_____DATE_____

TERMS: Net cash, all accounts billed due and payable 1 month following date of service. A service charge of 2.00% monthly (24% annually) applied to all balances over 30 days. A billing charge of $5.00 applied to all billed accounts.

Edited 3/19/2012