

**WEST KENDALL ANIMAL HOSPITAL
CLIENT REGISTRATION FORM**

CLIENT INFORMATION Title: (Mr.) (Mrs.) (Ms.) (Dr.) – Please circle one.

Last Name: _____ First Name: _____ Middle Initial: _____
Street Address: _____ Apt. # _____ City _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Driver's License # _____ Social Security # _____ E-mail: _____
Date of Birth: ____ / ____ / ____ Occupation: _____ How did you find us? _____

SPOUSE () or ALTERNATE CONTACT () – Please check one.

Last Name: _____ First Name: _____ Middle Initial: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

PET INFORMATION

Name: _____ Species: Cat () Dog () Bird () Rabbit () Other: _____
Breed: _____ Color: _____ Date of Birth: _____
Sex: Male () Female () Unknown () Has your pet been Spayed or Neutered? Yes () No ()

MEDICAL HISTORY

1. Is your dog or cat taking a heartworm preventative? Yes () No ()
If yes, please circle which one: Interceptor Sentinel Heartgard Revolution
2. What type of food and what brand do you feed your pet? _____
Que tipo de comida y que marca le esta dando de comer a su mascota?
3. What medical problems has your pet had in the past? *Que problemas o enfermedades ha tenido su mascota?*

4. Is your pet ... (Circle one) Inside only () Outside only () Spends time in each ()
5. Has your pet been exposed to any pets beyond those in your own household during the last month?
(For example, for boarding or grooming, or at a dog park?) _____
6. Are you presently using any flea or tick control product for your dog or cat? Yes () No ()
If yes, what product(s) are you using? _____
7. What is the primary reason your pet is here today? *Cual es la razon por la cual usted esta aqui hoy?* _____
8. Please write any additional information about your pet on the back of this form.

VACCINATION HISTORY

1. Last vaccinations were given on (Date) ____ / ____ / ____ by (Veterinarian's name) _____
2. Adverse vaccination reactions (swelling, anaphylaxis, tumor formation, etc.) can occur infrequently but are rarely fatal. *Reacciones adversas pueden ocurrir (hinchazón, reacción alérgica severa, formaciones de tumores, etc.) no con mucha frecuencia y son escasos los casos fatales.*

HOSPITAL POLICY

1. Fees for services rendered must be paid in full when your pet is discharged. Results cannot be guaranteed.
2. If you would like a written estimate, please request one.
3. WKAH staff must restrain all pets in the exam room. In order to avoid injury, please do not assist our staff.
4. A deposit is required for all pets being admitted for surgery, medical workups, and hospitalizations. The deposit amount will not be less than 50% of the estimated cost for the duration of treatment.
5. Payment is accepted as cash, local check, MasterCard, Visa, American Express, Discover, or debit card. A driver's license and/or other identification will be required when paying by check. All dishonored checks will be electronically debited and a processing fee will be applied.
6. Any pet that remains in our Hospital more than 24 hours without prior arrangement will be considered abandoned if we are unable to contact you at the phone numbers you gave us.

RESPONSIBILITY FOR PAYMENT

I assume responsibility for all charges incurred and agree that past due accounts are subject to a monthly billing fee. In addition, I agree to pay all collection costs, attorney's fees, and court costs in the even that this account is referred to an agency or an attorney for collection.

Signature: _____ Date: _____