SOUTH FEDERAL ANIMAL HOSPITAL

1100 South Federal Highway Fort Lauderdale, FL 33316

Accredited Member of the American Animal Hospital Association

PATIENT REGISTRATION FORM

☐Mr. ☐ Miss ☐ Mrs. ☐ Dr. Last name: _____ First name: _____

Address: _____ Apt#_____ City_____ State____ Zip_____

Place of Employment: _____ Referred By: _____

Spouse Place of Employment: _____

E-Mail Address: _____

Telephone: Home ( ) _____ Work ( ) _____

Spouse or Co-Owner's Name: _____ Home ( ) _____Work ( ) _____

Pet's Name: _____ ☐ Dog ☐ Cat **Sex**: ☐ Male intact ☐ Female intact ☐ Neutered male ☐ Spayed female

Breed: _____ **Color**: _____ **Pet's Date of Birth**: _____

Date of Last Vaccination: Distemper _____ Parvo_____ Rabies _____ Lepto _____ Bordetella _____
Lyme_____ Feline Distemper (FVRCP) _____ Feline Leukemia Vaccine_____

Date of last test: Heartworm test _____ FeLV/FIV Test _____ Fecal exam _____

Is Your Pet Allergic to Any Foods or Drugs? ☐ Yes ☐ No If **Yes**, Please list: _____

Current Medications (Include Heartworm Prevention and Flea Control): _____

Please check boxes to verify that you have read and consent to the terms.

☐ I am the owner of the above named animal or am responsible for it or have the authority to execute this consent on behalf of the owner. I am 18 years of age or older.

☐ I authorize South Federal Animal Hospital to administer any medication, tests, anesthetics, or surgical procedures that the doctor deems necessary for the health, safety, or well-being of my pet.

☐ I understand that as a prerequisite to my animal being admitted, vaccinations must be current and that my pet be free of external parasites (fleas and ticks), or these will be corrected at admission and charged accordingly.

☐ ***I UNDERSTAND THAT ALL FEES FOR PROFESSIONAL SERVICES ARE DUE AND PAYABLE AT THE TIME OF DISCHARGE. WE ARE HAPPY TO PROVIDE YOU WITH AN ESTIMATE UPON REQUEST.***

WE DO NOT ACCEPT CHECKS

I agree that if it becomes necessary to collect fees through the services of an attorney, either prior to litigation or after litigation is filed, I will pay all reasonable attorney fees and costs. In the event that I do not pay all or part of my bill when due, I will pay a **FINANCE CHARGE OF 18% PER ANNUM (1.5% PER MONTH**) of the unpaid balance, and any judgment obtained against me for amounts that I owe.

THIS INFORMATION MUST BE FILLED IN FULL

Driver's License Number: _____ State issued: _____

Someone who does not live with you in case we cannot reach you:

Name: _____ Telephone: _____

Signature: _____ Date: _____