

**SOUTH FEDERAL ANIMAL HOSPITAL**  
**1230 S. Andrews Ave 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: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
Telephone: Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Spouse or  
Co-Owner's Name: \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ **Pet's**  
**Name:** \_\_\_\_\_  Dog or  Cat Sex:  Male Intact  Male Neutered  Female Intact  Female Spayed  
**Breed:** \_\_\_\_\_ **Color:** \_\_\_\_\_ **Pet's Date of Birth:** \_\_\_\_\_  
Date of Last Vaccination: \_\_\_\_\_  
Dogs: Rabies \_\_\_\_\_ Canine Distemper (DHPP) \_\_\_\_\_ Lepto \_\_\_\_\_ Bordetella \_\_\_\_\_ Lyme \_\_\_\_\_  
Cats: Rabies \_\_\_\_\_ Feline Distemper (FVRCP) \_\_\_\_\_ Feline Leukemia Vaccine (FeLV) \_\_\_\_\_  
Date of last test: Heartworm test \_\_\_\_\_ FeLV/FIV Test \_\_\_\_\_ Fecal exam \_\_\_\_\_ Is Your Pet  
Allergic to Any Foods, or Drugs, or Vaccines? Yes No If **Yes**, Please list: \_\_\_\_\_

**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 consent to the audio recording and AI-assisted transcription of my visit for medical record documentation. Records are used internally and kept confidential.
- I UNDERSTAND THAT PAYMENT FOR PROFESSIONAL SERVICES IS EXPECTED WHEN SERVICES ARE RENDERED. WE ACCEPT CASH, DEBIT, CREDIT CARDS, AND CARE CREDIT. WE ARE HAPPY TO PROVIDE YOU WITH A WRITTEN 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/ID Number: \_\_\_\_\_ State issued: \_\_\_\_\_

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

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_