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 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: _____