PATIENT (PET) REGISTRATION

#1

Name ______________________________________ Age/DOB____________________________

Dog / Cat / Other_________ Breed _________________________ ☐Male ☐Female

Color _____________________________ ☐Male/Neutered ☐Female/Spayed

#2

Name ____ Age/DOB____________________________

Dog / Cat / Other_________ Breed _______________________ ☐Male ☐Female

Color _____________________________ ☐Male/Neutered ☐Female/Spayed

#3

Name ______________________________________ Age/DOB____________________________

Dog / Cat / Other_________ Breed _________________________ ☐Male ☐Female

Color _____________________________ ☐Male/Neutered ☐Female/Spayed

#4

Name ______________________________________ Age/DOB____________________________

Dog / Cat / Other_________ Breed _________________________ ☐Male ☐Female

Color _____________________________ ☐Male/Neutered ☐Female/Spayed

PLEASE READ AND SIGN. I give permission for medical records or vaccinations dates for any of my pets that have been treated at Madison Companion Animal Hospital to be given verbally, by mail, or by fax to other animal hospitals, boarding facilities, or grooming facilities that may request them for future treatment of my animals.

Signature of Owner or Agent ____________________________________ Date ___________________

Madison Companion Animal Hospital

2658 South Seminole Trail, Madison, VA 22727

CLIENT REGISTRATION

Thank you for choosing our animal hospital. We pride ourselves in offering high quality medical care and emphasize preventative medicine. We look forward to serving you and caring for your pet's needs for many years to come. Please complete this form so we can accurately enter you into our files. We look forward to serving you and your family.

You must be at least age 18 and provide proper identification to register your pet(s) in your name.

Owner's Name ___________________________________ Date of Birth __/___/____ Social Sec # _______________________

Driver's License #: _____________________________State _____________

Spouse/Other ___________________________________ Date of Birth __/___/____ Social Sec # _______________________

Driver's License #: _____________________________ State _____________

Mailing Address _____________________________________ City _______________________ St ________ Zip ____________

Home Phone # (_____) ________________ Cell Phone # (_____) __________________ Work Phone #(____)______________

Email ____________________________________(For Vaccine Reminders, etc) Employer: _______________________________________

Preferred Emergency Contact Name ________________________________ Phone: _________________________

How did you hear about our clinic? ___ Local Yellow Pages ___Charlottesville Yellow Pages

___ Internet Search ___ Facebook ___ Animal Shelter (which one? _________________)

___ Sign ___ Previous Client ___ Previous Vet ___ Local Newspaper

___ Referral from someone we may thank? __________________________________

Dear Client,

We pledge to do our very best to care for your pet's health needs. In return we ask you to accept the responsibility for charges incurred in the treatment of your pet and accept that **payment is due when services are rendered.**

Please feel free to ask for an **Estimate** of today's costs. We are happy to discuss treatment options and costs before providing services to your pet.

- **Payment is due in full at the time of service**. We accept cash and/or credit cards; VISA, MasterCard, Discover, and Care Credit.
- **How do you plan to pay for today's services?** Circle One: **Cash** **Debit/Credit Card** **CareCredit**

Agreement terms: Balances due over 30 days will be charged a 1.5%/mo interest charge (18% APR). Additional collection fees will be charged if your past-due account is sent to Collections or Small Claims Court.

Client Agreement and Signature: ____ Date: _____________________

Clinic Use: Client ID: ____________ NCP _____ NCC _____