



CONFIDENTIAL CLIENT REGISTRATION

Thank you for giving Irving Pet Hospital the opportunity to care for your animal companion. Please complete the following so that we may become better acquainted.

OWNER INFORMATION:

Name: _____ Owner Date Of Birth: _____
Co-Owner/Spouse: _____
Address: _____
City: _____ State/Zip: _____
Primary Phone #: _____ Secondary Phone #: _____
Co-Owner/Spouse Phone #: _____ Email: _____

Ok to receive reminders via text _____ If so, at which number? (please circle) Primary OR Secondary
Ok to receive reminders and receipts via email _____
Ok to use your pet's image on our social media outlets _____

HOW DID YOU BECOME AWARE OF OUR HOSPITAL? (whom may we thank?)

Online Search (please circle) AOL Bing City Search Google Yahoo! Yellow Pages
____ Yelp ____ Facebook ____ Sign ____ Instagram ____ Pet Store
____ Richmond Review ____ Sunset Beacon
Rescue Society _____ Other Hospital _____
Personal Recommendation _____

Pet's Name: _____ Species: Canine Feline Breed: _____ __Male __Female Neutered/Spayed? Y N Color: _____ Birth date or age: _____ Date of last vaccination(s): _____ DHLPP / FVRCP: _____ RABIES: _____ LYME / FELV: _____ OTHER: _____	Pet's Name: _____ Species: Canine Feline Breed: _____ __Male __Female Neutered/Spayed? Y N Color: _____ Birth date or age: _____ Date of last vaccination(s): _____ DHLPP / FVRCP: _____ RABIES: _____ LYME / FELV: _____ OTHER: _____	Pet's Name: _____ Species: Canine Feline Breed: _____ __Male __Female Neutered/Spayed? Y N Color: _____ Birth date or age: _____ Date of last vaccination(s): _____ DHLPP / FVRCP: _____ RABIES: _____ LYME / FELV: _____ OTHER: _____
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The undersigned hereby acknowledges that s/he is entering into an agreement with Irving Street Veterinary Hospital for veterinary services. As owner or authorized agent, I understand that the hospital shall obtain permission for treatment from the person presenting the patient and shall provide an estimate of costs. I also realize that in the event of unforeseen circumstance, emergency measures may have to be instituted before my permission can be obtained. Fees are due and payable at the time services are rendered. A deposit may be required prior to performing service. Any past due accounts will be charged a finance charge of 1.75% monthly which is an annual percentage of 21% as well as a billing charge of \$2.50 per month. There will be a service charge of \$25.00 on all returned checks. Any account requiring outside collection will be charged all applicable collection fees incurred by this hospital. I have read the above and hereby authorize the veterinarian to examine, prescribe for, or treat the above pet(s). I assume responsibility for all charges incurred in the care of the animal. I also understand that ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.

Signature: _____ Date: _____

OUR BUSINESS CONTINUES TO GROW WITH REFERRALS FROM OUR CLIENTS. IF YOU ARE HAPPY WITH US, PLEASE TELL YOUR FRIENDS. IF NOT, PLEASE TELL US!