



COCO-PARK

ANIMAL HOSPITAL

Client Registration Form

PET OWNER INFORMATION:

Mr. Mrs. Ms. Miss. Dr. **Date:** _____ **Name of Pet Insurance:** _____

Owner's Name: _____ **Spouse/Other Agent** (include relationship): _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ ext. _____ **Which is your primary phone number?:** Home ____ Work ____ Cell ____

***Email address:** _____

Emergency Contact (not living with you): _____ **Phone:** _____

*Information will not be sold or shared for mass e-mail purposes, for hospital use only.

PATIENT INFORMATION:

Pet's Name: _____ **Species** (Dog/Cat/Other): _____

Date of birth/age: _____ **Breed:** _____ **Color:** _____

Sex: Male intact Male neutered Female intact Female spayed

Is there anything that makes your pet uncomfortable (ie. men, hats, body handling)? _____

Pet's Name: _____ **Species** (Dog/Cat/Other): _____

Date of birth/age: _____ **Breed:** _____ **Color:** _____

Sex: Male intact Male neutered Female intact Female spayed

Is there anything that makes your pet uncomfortable (ie. men, hats, body handling)? _____

Please indicate when you pet was last vaccinated, OR where we may obtain your pet's health care records.

Canine: Rabies _____ DHPP _____ Bordetella _____ Other _____

Feline: Rabies _____ FVRCP _____ Feline leukemia _____ Other _____

Hospital: _____ **Doctor's Name:** _____ **Phone:** _____

HOW DID YOU HEAR ABOUT OUR HOSPITAL?

Coco-Park Animal Hospital client or employee (name): _____

Internet/Website Location/Drive By Coral Springs/Parkland/Margate/Boca Raton City News Direct Mailer

Woman to Woman Yellow Pages Clipper Magazine Sharp Saver Val Pak Facebook Money Mailer

PAYMENT POLICY: PLEASE READ

ALL FEES FOR PROFESSIONAL SERVICES ARE DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED. It is our policy to provide you with a written estimate of fees for any case where hospitalization or emergency care is necessary. **A deposit prior to hospitalization is required. The balance is due at discharge.** I agree, in the event that any amount becomes past due more than 30 days, to pay interest thereof at 18% annum (1.5% per month), plus a monthly billing charge of \$5.00 from the date the charges were incurred. In the event that it becomes necessary to collect fees through the services of an attorney or other collection agency, either prior to or at trial, I agree to pay all reasonable attorney's fees and/or collection agency fees incurred. I am the legal owner, or the representative of the animal being presented for treatment, and I am over 18 years of age.

Signature: _____ **Date:** _____

*My signature authorizes Coco-Park Animal Hospital to conduct video and audio recording for training and quality assurance and to utilize photographic images of myself or my pet taken on hospital premises in advertising and/or marketing affiliated with Coco-Park Animal Hospital.



For office use only: Copy of valid driver's license or, if not available, other photo ID

Date: _____ **Time:** _____ **Staff initials:** _____