Adirondack Animal Hospital
Patient Registration Form

Entered By:

Today's Date_____

Mr.
Mrs.
Miss/Ms._____ E-mail _____

LAST NAME FIRST NAME MIDDLE NAME SPOUSE'S FIRST NAME

ADDRESS_____
NUMBER STREET CITY ZIP

HOME PHONE_____ WORK PHONE_____

EMPLOYER_____ _____ _____
OCCUPATION How long Employed

SPOUSE'S EMPLOYER_____ _____ _____
WORK PHONE OCCUPATION

REFERRED BY_____ DRIVER'S LIC. NO._____

I certify that I own the below described animal(s) and I do hereby consent and authorize the Adirondack Animal Hospital, to board or hospitalize it and to administer any vaccinations, medication, test, surgical procedures or treatments that the doctors deem necessary for the health, safety, or well-being of the animal while it is under Adirondack Animal Hospital's care and supervision. I fully understand that my pet will be discharged only during regular office hours and all fees for services must be paid in full at the time of discharge.

If I neglect to pick up the animal(s) within 5 days notice of discharge, Adirondack Animal Hospital may consider my animal(s) abandoned according to N.Y. Agriculture and Markets law. However, even in the event that I refuse to pick up my animals(s), I still agree to pay any charges incurred for care and disposal as well as any collection cost. In the event of legal action to enforce any terms hereof, the non prevailing party agrees to the payment of any and all costs and expenses, including, but not necessarily limited to reasonable attorney's fees and the court costs incurred.

Any fees not paid within 30 days shall be subject to a finance charge of 2% per month (24% per anum).

I CERTIFY THAT I HAVE READ THE FOREGOING, THAT I UNDERSTAND THE PROVISIONS THEREOF, AND THAT I AGREE TO ABIDE BY SUCH PROVISIONS AND THAT THEY SHALL APPLY TO ANY AND ALL ANIMALS THAT I MAY BRING IN ON THIS OR ANY FUTURE DATE.

Date_____Signed_____Spouse_____

PET INFORMATION

DOG	CAT	Other	Name	Breed	DESCRIPTION	Date of Birth	SEX	Altered	WT.	Date of Last Immunization or Examination			
										D-H-L-P	Rabies	FVR-C-P	FELV
								☐ Yes ☐ No					
								☐ Yes ☐ No					
								☐ Yes ☐ No					

PAYMENT AT TIME OF SERVICE RENDERED

☐ **PERSONAL CHECK** (Need 2 forms of I.D.) ☐ **CASH**
Bank Name _____
Account No._____

☐ **CARE CREDIT** (Requires Application)

☐ **VISA**
Account #_____

☐ **MASTERCARD**
Account #_____