



Sunset Animal Hospital

Thank you for giving Sunset Animal Hospital the opportunity to care for your pet(s).
So that we may become better acquainted, please complete the following:

Registration Form

Client # _____

Name _____ Birthdate ____/____/____
Last First Middle Initial

Address _____
Street City Zip/State

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____
Company Street/ City Zip/ State

Driver's License # _____ State _____ Email Address: _____

Spouse's or Co-Owner's Name _____
Last First Middle Initial

Address _____
Street City Zip/ State

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____
Company Street/ City Zip/ State

Driver's License # _____ State _____ Email Address: _____

If necessary, may we call you at work? **Yes** **No**

How did you become aware of our hospital? **Sign** **Yellow Pages** **Internet** **Other**
 One of our clients? Whom may we thank for the referral? _____

Professional Fees are due at the time service is rendered

Please check preferred method of payment: **Cash** **Check (ID Required)** **Visa/ MC** **Care Credit**
 Discover/ American Express

I, the undersigned owner, or owner's agent, of the pet identified above, certify that **I am** over 18 years of age. I hereby authorize Sunset Animal Hospital to examine, prescribe medication for, treat, hospitalize, or perform surgery upon pet(s) registered to me. I also consent to the administration of such anesthetics as necessary. I understand that there is some risk with general anesthesia and no guarantee is made as to the result or cure of procedures or operations and I am encouraged to discuss any concerns I have about those risks with my attending veterinarian before the procedure is initiated. Additionally, overnight hospitalization options will be discussed with the attending doctor, as the continuous presence of qualified personnel may not be provided at all times.

I understand that an estimate of the costs for veterinary services will be provided to me and that I am encouraged to discuss all fees attendant to such care before services are rendered and during my pet's ongoing medical treatment. If my pet is hospitalized, I agree to pay a deposit of 50% of the estimated fees and assume financial responsibility for the balance of all services rendered on a cash, credit card or check basis at the time my pet is discharged from the hospital. In the event my pet is hospitalized for more than 48 hours and my attending veterinarian is unable to reach me, I understand it is my responsibility to call the hospital at least every 24 hours to inquire as to the medical status of my pet and the fees incurred for medical services up to that day.

Signature _____ Date _____
Owner/ Authorized Agent

Would you like us to request medical records to be faxed from another veterinary hospital? **Yes No**

Name of hospital _____ City _____

Pet (1) Pet's Name _____ Species _____

Breed _____ Color _____ Sex **M F** Spayed/ Neutered **Yes No**

Birth Date ____/ ____/ ____ Allergies or significant information we should know _____

Vaccination _____ Date _____

Vaccination _____ Date _____

Vaccination _____ Date _____

Pet (2) Pet's Name _____ Species _____

Breed _____ Color _____ Sex **M F** Spayed/ Neutered **Yes No**

Birth Date ____/ ____/ ____ Allergies or significant information we should know _____

Vaccination _____ Date _____

Vaccination _____ Date _____

Vaccination _____ Date _____

Pet (3) Pet's Name _____ Species _____

Breed _____ Color _____ Sex **M F** Spayed/ Neutered **Yes No**

Birth Date ____/ ____/ ____ Allergies or significant information we should know _____

Vaccination _____ Date _____

Vaccination _____ Date _____

Vaccination _____ Date _____

Pet (4) Pet's Name _____ Species _____

Breed _____ Color _____ Sex **M F** Spayed/ Neutered **Yes No**

Birth Date ____/ ____/ ____ Allergies or significant information we should know _____

Vaccination _____ Date _____

Vaccination _____ Date _____

Vaccination _____ Date _____
