Welcome to Cottage Pet Hospital!

900 E. Broadway * Anaheim, CA. 92805
Phone (714) 535-6714
www.cottagepetshospital.com

Thank you for giving us the opportunity to care for your pet. We're happy to help you with all your pets needs. To insure the best care possible, please take the time to fill in this form completely. Thank you!

New Client Registration

Primary Owner _____ SS#_____-_____-_____

Secondary Owner _____ SS#_____-_____-_____

Address _____ City_____

State_____ Zip Code_____ Home Phone (___)_____

Primary Cell (___) _____ Work (___) _____ Employer _____

Secondary Cell (___) _____ Work (___) _____ Employer _____

E-Mail Address(es) _____ _____

Please tell us how you prefer to pay your bill (Please circle one)

Cash Check Credit Card Debit Care Credit

Please note: If paying by Check, we require both a Valid Driver's License/State Issued I.D. AND Social Security Number be provided.

Driver's License/State I.D. #_____ Exp. Date_____ State_____ D.O.B._____

How did you learn about our hospital? (Please circle one) Sign Here Previously

Phone Book (which?) _____ Internet (which site?)_____

Friend/Relative - If so, whom may we thank?

New Pet Information

Pet's Name_____ Dog or Cat Breed_____ Age _____

Color _____ Male or Female Spayed/Neutered Microchip? Yes No

Reason for today's visit? _____

Previous Doctor/Hospital's name? _____ May we request records? Yes No

What was the last kind of treatment? _____

Previous Medical History/Treatment/Surgery _____

Vaccination History _____

Type of flea control? _____ Type of food? _____

I, the undersigned, owner or authorized agent of the above patient, hereby authorize the admitting veterinarian (and his designated associates or assistants) to administer such treatment as needed for the benefit of this patient. I also consent to the administration of such anesthetics as needed. I DO / DO NOT AUTHORIZE ADDITIONAL TREATMENT (IF NEEDED) SHOULD I BE UNABLE TO BE REACHED_____ (initial). I further understand that no guarantee of successful treatment is made. I also assume financial responsibility for all charges incurred to this patient, and agree to pay all such charges at the time the patient is released.

PAYMENT DUE AT TIME OF SERVICES

Signature of Owner/Agent_____ Date_____