WELCOME TO COTTAGE PET HOSPITAL!

900 E. Broadway · Anaheim, CA 92805
Phone: (714) 535-6714 · Fax: (714) 535-0564
www.cottagepethospital.com · cottagepethospital@live.com

NEW CLIENT REGISTRATION

Primary Owner ______________________ SS# ____________ (Last 4 digits)

Secondary Owner ______________________ SS# ____________ (Last 4 digits)

Address ______________________ Apt# ________ City ______________

State ________ Zip Code ________ Employer ______________________

Preferred Contact Phone # ( ) ______________ Home work cell (Please select one)

2nd Contact Phone # ( ) ______________ Home work cell (Please select one)

Can We Send You Text Message Notifications? Yes no if yes, Phone # ( ) ______________

Email Address ______________________

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

Cash Check Credit Card Debit Care Credit (Ask us for details!)

Please note: if paying by check we require both a Valid Driver's license/State I.D. AND Social Security number. If paying by card we require a Valid Driver's license/State I.D.

Driver's License/State I.D. # ______________ Exp. Date ________ State ______ D.O.B. ________

How did you learn about our hospital? (Please select one)

Sign Here Previously Internet (Please select one) Yelp Google Yahoo Bing Other site ______________

Friend/Relative (Whom may we thank?) ______________ Other ______________

NEW PET REGISTRATION

Pet's Name ______________ Dog or Cat Breed ________ Age ______

Color ______________ Male Female Spayed/Neuter? Y N Microchip? Y N # ________

Reason for today's visit ______________________

Previous Doctor/Hospital Name ______________________ May we request records? Y N

Previous Medical History/Treatment/Surgery ______________________

Vaccination History ______________________

Do you have pet insurance? Y N If Yes, which company ______________________

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 (circle one) _______ (initial). AUTHORIZE ADDITIONAL TREATMENT (IF NEEDED) SHOULD I BE UNABLE TO BE REACHED. 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. If any portion of the bill is not paid in full within one month, there will be a monthly finance rate of 1.5% and a $4.00 billing charge for each month it remains unpaid. You are responsible for all fees including 25% collection fee if your account is sent to collections and/or court fees.

PAYMENT IS DUE AT TIME OF SERVICE.

Signature of Primary Owner/Agent X ______________________ Date ________

Signature of Secondary Owner/Agent X ______________________ Date ________

Thank you for giving us the opportunity to care for your pet. To ensure the best possible care, please take the time to fill in this form completely. Thank you!