Academy Pet Hospital
Client Registration Form

Thank you for the opportunity to care for your pet. We will be happy to answer any questions you may have about your pet's health. For the smoothest visit possible, please take the time to fill in this form completely and email it to us at Academypet1@gmail.com. **PLEASE COMPLETE IN ALL SPACES!**

OWNER'S NAME: _____ SPOUSE/OTHER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PRIMARY NUMBER: _____ CELL: _____ WORK: _____

SPOUSE/OTHER CELL: _____ WORK: _____

DRIVER'S LICENSE #: _____ STATE: _____ EXPIRATION: _____

HOW DID YOU HEAR ABOUT US: ◯ Recommendation ◯ Website ◯ Facebook ◯ Sign Other_____

IF RECOMMENDED, WHO CAN WE THANK? _____

Would you like to manage your pet's life at home?
By giving us your e-mail address, you will be able to use your pet portal to check your pet's medical records, request appointments and boarding, request medication and food refills plus more! Be confident that we will keep your e-mail address *private*.

E-mail address: _____

PET HEALTH HISTORY:

Pet's Name	Cat	Dog	Other	Birthdate	F/M	S/N	Breed	Color

Previous Veterinarian: _____

☐ I hereby authorize the veterinarians at ACADEMY PET HOSPITAL to examine, prescribe for, and treat the above described pet(s). I agree to pay for all services rendered and medications, goods, and supplies when purchased. I understand that a deposit may be required for surgical or medical treatment. All accounts not paid in full within 30 days will be subject to a late charge of 1 ½ percent per month (18% per annum) on the unpaid balance. In the event of default, the undersigned further agrees to pay reasonable attorney fees (not to exceed 50% of the unpaid balance) and court costs, in addition to any late charges applicable. **ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.**

☐ I understand that ACADEMY PET HOSPITAL requires scheduled appointments to be seen. If I am unable to make my scheduled appointment, I will make every effort to contact ACADEMY PET HOSPITAL at least 24 hours prior to my appointment. **I understand if I miss my appointment without prior notice, my account will be charged a $35.00 missed appointment fee. Missed surgical appointment will be charged a $55.00 fee.**

By my signature below, I hereby agree to all of the above and acknowledge the receipt of a copy of this agreement (upon request).

Signature of Owner or Agent: _____ Date: _____