Four Corners Veterinary Hospital

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

AAHA ACCREDITED
The Standard of Veterinary Excellence

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: _____

Please note which number you would like to be the primary contact number

Home **Work** **Cell**

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

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

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 Four Corners Veterinary 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

Turn over for Pet Information

Pet Information Form

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 _____