BEACH BLVD PET HOSPITAL
CLIENT REGISTRATION

Client Information (please print) *this information is required
*Owner:
Mr.
Mrs. _____ Spouse's Name_____
Ms. (LAST) (FIRST) (MI)

*Street Address: _____
(no P.O. Box Please)
*City/State/Zip Code: _____

*Home Phone:_____ Work Phone: _____ Cell Phone: _____
*Referred by: _____ (Ask about our Client Referral Program)
*Employed by:_____ *E-mail Address: _____
*Driver's License #:_____*Date of Birth_____ *SS#_____
(last 4 digits only)

Patient Information
Pet's Name: _____ Date of Birth: _____
Dog Cat Other:_____ Breed:_____ Color_____
Sex: (Please circle) Male or Female Spayed / Neutered (please circle if applicable)
Sensitivities : (Bee stings, vaccines, medications, etc) _____
Past Serious injuries or Surgeries: _____
Other Comments: _____

Patient Information
Pet's Name: _____ Date of Birth: _____
Dog Cat Other:_____ Breed:_____ Color_____
Sex: (Please circle) Male or Female Spayed / Neutered (please circle if applicable)
Sensitivities : (Bee stings, vaccines, medications, etc) _____
Past Serious injuries or Surgeries: _____
Other Comments: _____

I am the legal owner, or authorized agent of the legal owner, of the pet(s) being presented for veterinary medical care, and I am over the age of 18 years. I understand that all the fees are due upon release of the pet(s) unless specific arrangements are made with the hospital management BEFORE services are rendered. I understand and agree that all above information is accurate to the best of my knowledge and that client/patient records may be released to a third party who provides, among other things, continuing education, quality control, customer services or debt collection services. When paying with a check, your social security number is required and all dishonored checks will have a processing fee with applicable taxes applied. I will assume responsibility for any and all collection fees.

Date:_____ Signature:_____

Print Name: _____