



NEW TAMPA ANIMAL HOSPITAL

CLIENT REGISTRATION

Owner's Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell/Other** _____

Email Address: _____

Occupation: _____ **Employer:** _____ **Work Phone:** _____

Alternate Contact _____ **Phone** _____ []Spouse []Partner []Co-Owner

How did you hear about us? [] Drove-By [] Yellow Pages [] Pet Resort referral [] Newspaper ad
[] Personal referral _____ [] Other _____

PET INFORMATION

Pet's Name _____ [] Dog [] Cat [] Other _____

Birthdate/Age _____ **Sex:** [] Male [] Male Neutered [] Female [] Female Spayed

Breed _____ **Color** _____

Any other information you would like us to know: _____

Pet's Name _____ [] Dog [] Cat [] Other _____

Birthdate/Age _____ **Sex:** [] Male [] Male Neutered [] Female [] Female Spayed

Breed _____ **Color** _____

Any other information you would like us to know: _____

In admitting my pet(s) for diagnostics, treatment or surgery, I authorize the veterinarians of New Tampa Animal Hospital, and their support staff, to administer such treatment and/or perform such diagnostic or surgical procedures as deemed necessary. It is understood that an estimate of charges will be given for services on request. No guarantee or assurance can be made as to the results that may be obtained. I fully understand there may be risk associated with any procedure. I understand that a deposit of 50% may be required before services are performed and I assume full financial responsibility for charges incurred by my pet. I realize that these charges may exceed a given estimate if complications arise. I understand that I will be contacted prior to treatment, if possible, should complications occur. All professional fees are due at the time services are performed. There is a \$45.00 charge for any check returned unpaid.

Signature _____ **Date** _____