BEST FRIENDS VETERINARY HOSPITAL

Last Name_____ First Name_____

Others Authorized for Account: Please list who can make an appointment, authorize treatment, or make a payment.

Name _____ Relationship_____
Name _____ Relationship_____
Name _____ Relationship_____

Street Address_____ Apt: _____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Spouse Name_____ Cell Phone _____ Work Phone_____

E-mail Address_____

[redacted]

☐ Internet ☐ Drive By / Saw Sign ☐ Yellow Pages ☐ Other_____

☐ Personal Recommendation (whom may we thank?)_____

[redacted]

By signing this release, I hereby give Best Friends Veterinary Hospital my permission to use my pet's images for any purpose, which may include advertising, promotion, face-book, and marketing.

Sign Here: _____

PATIENT INFORMATION

Pet Name_____Species/Breed_____Age_____ Sex_____ S N
Pet Name_____Species/Breed_____Age_____ Sex_____ S N
Pet Name_____Species/Breed_____Age_____ Sex_____ S N
Pet Name_____Species/Breed_____Age_____ Sex_____ S N

Hospital Disclosures

I understand that payment is due at time of service and that the following forms of payment are accepted: Visa, MasterCard, Discover, American Express, Cash, and Care Credit

I understand that Best Friends Veterinary Hospital is not a 24-hour hospital facility and that I can request for my pets to be transferred to an emergency veterinary hospital with 24-hour care if overnight hospitalization is required.

California State law requires us to have our client's date of birth to dispense certain types of medications such as pain-relivers and sedatives. In order to provide outstanding veterinary customer service, this facility is equipped with full audio/video monitoring for quality assurance and training purposes.

Signature of financially responsible party: X_____ Date: _____

CDL: _____ State: _____ Owner's Date of Birth: _____