SOUTHPORT ANIMAL HOSPITAL

Bob Hagadorn D.V.M. , Kelli Marlar D.V.M.

Thank you for giving us the opportunity to care for your pet. We'll be happy to answer any questions you have about your pet's health. To insure the best care possible, please take time to fill in this form completely. Thank You!

Registration

Owner _____

Partner/Spouse _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Work Phone _____

Alt Phone _____ Email _____

Emergency Contact Name _____ Phone _____

Referral Name _____ Walk-in _____ Other _____

Reason for visit _____

Pet Health History

Name of Pet #1 _____ Breed _____

Color _____ Birthdate _____ Male / Female **Fixed:** Yes / No

Name of Pet #2 _____ Breed _____

Color _____ Birthdate _____ Male / Female **Fixed:** Yes / No

Previous Animal Hospital _____ Date of Last Vaccinations _____

List of prior diseases, surgical procedures, injuries, allergies, and current medications:

_____

Authorization

I hereby authorize Southport Animal Hospital to examine, prescribe for, or treat the above-described pet. I assume responsibility for all charges incurred in the care of this animal. I also understand that **all charges will be paid at the time of release** and that a deposit may be required for treatment. In the event it becomes necessary to collect these fees through an attorney or collection agency, then I agree to pay all attorney fees, collection fees, filing fees, financial charges, interest charges, and any other cost incurred. It is agreed that the venue for all actions will be in Broward County, Florida. **Please provide us with a copy of your driver's license. This is mandatory before treatment can be given.** ***WE DO NOT ACCEPT CHECKS!***

Signature of Owner or Agent _____

Drivers License # _____ Date _____

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