ARROWHEAD VETERINARY HOSPITAL INC.

1620 L Road, Fruita, CO 81521 T: (970) 858-8881 F: (970) 858-9367 www.arrowheadvethospital.com

CLIENT REGISTRATION FORM

Name: _____
Last First Middle Intl.

Physical Address:_____**City**_____**State**_____**Zip**_____

Mailing Address (if different):_____

Home Phone (___)_____**Cell Phone(___)**_____**Alternate Phone(___)**_____

Employer:_____ **Work Phone(___)**_____

Driver's License Number: _____**State:**_____ **Email Address:**_____

Spouse or Co-Owner's Name:_____ **Spouse's Employer:** _____

Emergency Contact:_____**Relationship:**_____**Phone No.(___)**_____

How did you first hear of us?

☐ **Friend. Who may we thank?** _____

☐ **Hospital Sign** ☐ **Shopping Cart** ☐ **Fruita Activity Guide** ☐ **Other**_____

Phone Book? ☐ **Yellow Book** ☐ **Mesa County** ☐ **Dex**

☐ **Internet: Which site?** _____ ☐ **Facebook** ☐**Arrowhead Website**

Pet Information

PLEASE LIST ALL PETS YOU CURRENTLY OWN (EXTRA SHEET AVAILABLE IF ANIMALS EXCEED ALOTTED SPACE)

PET'S NAME	SPECIES			AGE	SEX			BREED	COLOR
	DOG	CAT	OTHER		M	F	NEUT/SPAY		

I hereby authorize the veterinarian to examine, prescribe for, and/or treat the above described pet(s). I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid in full at the time of release and that a deposit may be required for medical and surgical treatment. In the event that my account is past due or outstanding I understand that a $10.00 billing fee will be applied to my account after 30 days and every 30 days thereafter until my account is paid in full. I agree to pay a $25.00 cost of collection in the event that any collection efforts are undertaken for past due amounts. If the services of an attorney are used, I agree to pay reasonable attorney's fees and all court costs actually incurred. We respectfully request 24 hours' notice on cancelled or rescheduled appointments. Fees may apply for appointments not cancelled in advance. Please check form of payment:

Method of Payment: ☐***CASH*** ☐***CHECK*** ☐***CREDIT CARD*** ☐***CARE CREDIT***

_____ _____
Signature of Owner/Agent Date

REVISED.CJ.FEBRUARY2013

OFFICE USE ONLY

Client confirmed that all the information provided is current and accurate ______ ________________
Date

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