Plantation Animal Hospital

Client Information:

Last Name:______________________________ First Name:_____________________________

Best Contact #:(_____)_____________________ Other #:
(_____)___________________________

Address:____ City______________ Zip:__________

Employer:______________________________
Occupation:_________________________________

Work Phone(____)__________________
Ext:____*EMAIL:_________________________________

How did you find out about us?____

Other Responsible Party:

Last Name:_____________________________ First
Name:________________________________

Best Contact #:(____)_______________________ Other #:
(____)____________________________

Address:____ City______________
Zip:__________

Employer:______________________________
Occupation:________________________________

Work Phone(____)___________________
Ext:_____*EMAIL:__________________________________

Pet Information:

Name:____________________ Canine___ Feline____ Other___
Breed__________________

Color:_____________ Sex: M____ F____ Altered? Yes_____ Not Yet_____ Breeding?_____

Age/Birthday________ Current Vaccinations? Yes___No___ Previous Records at
____

Payment is due when services are rendered. Pets under the care of Plantation Animal Hospital that require emergency medical care will be given such care until the above said owner can be contacted and a mutually agreed on course of treatment determined. All necessary medical treatments and/or procedures to sustain your pets health will be performed in accordance with the Florida State Veterinary Medical Board at the expense of the above said owner. This office is not staffed 24 hours a day. Plantation Animal Hospital is monitored by a security system and hospital personnel will be notified in the event of an emergency. By signing below you, the above said owner agree to these terms, and indicate the information above is true to the best of your knowledge.

Signature:____
Date:_________________________