

**SOUTH FEDERAL ANIMAL HOSPITAL**

**1100 South Federal Highway**

**Fort Lauderdale, FL 33316**

**Accredited Member of the American Animal Hospital Association**

**PATIENT REGISTRATION FORM**

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Mr. Miss Mrs. Dr.  
Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Place of Employment \_\_\_\_\_  
Spouse Place of Employment \_\_\_\_\_  
E-Mail Address \_\_\_\_\_  
Telephone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Spouse Work ( ) \_\_\_\_\_  
Spouse or Co-Owner's Name \_\_\_\_\_ Referred By \_\_\_\_\_

Pet's Name: \_\_\_\_\_  Dog  Cat Breed: \_\_\_\_\_  
Pet's Date of Birth: \_\_\_\_\_ Sex: M F Spayed/Neutered: Yes  No  
Color: \_\_\_\_\_  
Date of Last Vaccination: Distemper \_\_\_\_\_ Parvo \_\_\_\_\_ Rabies \_\_\_\_\_ Corona \_\_\_\_\_  
Bordetella \_\_\_\_\_ Lyme \_\_\_\_\_ | Feline Distemper (FVRCP) \_\_\_\_\_ Feline Leukemia Vaccine \_\_\_\_\_  
Date of last test: Heartworm test \_\_\_\_\_ FeLV/FIV Test \_\_\_\_\_

Is Your Pet Allergic to Any Foods or Drugs? Yes  No  If Yes, Please list: \_\_\_\_\_  
Current Medications (Include Heartworm Prevention and Flea Control): \_\_\_\_\_

Please check boxes to verify that you have read and consent to the terms.

- I am the owner of the above named animal or am responsible for it or have the authority to execute this consent on behalf of the owner. I am 18 years of age or older.**
- I authorize South Federal Animal Hospital to administer any medication, tests, anesthetics, or surgical procedures that the doctor deems necessary for the health, safety, or well-being of my pet.**
- I understand that as a prerequisite to my animal being admitted, vaccinations must be current and that my pet be free of external parasites (fleas and ticks), or these will be corrected at admission and charged accordingly.**
- I UNDERSTAND THAT ALL FEES FOR PROFESSIONAL SERVICES ARE DUE AND PAYABLE AT THE TIME OF DISCHARGE. WE ARE HAPPY TO PROVIDE YOU WITH AN ESTIMATE UPON REQUEST.**

***WE DO NOT ACCEPT CHECKS***

I agree that if it becomes necessary to collect fees through the services of an attorney, either prior to litigation or after litigation is filed, I will pay all reasonable attorney fees and costs. In the event that I do not pay all or part of my bill when due, I will pay a **FINANCE CHARGE OF 18% PER ANNUM (1.5% PER MONTH)** of the unpaid balance, and any judgment obtained against me for amounts that I owe.

**THIS INFORMATION MUST BE FILLED IN FULL**

Driver's License Number: \_\_\_\_\_ State issued: \_\_\_\_\_

Someone who does not live with you in case we cannot reach you.

Name: \_\_\_\_\_ Telephone \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_