

**Animal Health Center of Land O' Lakes**  
**Client Registration**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last, First, MI

Address: \_\_\_\_\_  
Street  
\_\_\_\_\_  
City State Zip Code

Telephone Numbers (please include area code and check preferred contact):

Home: (\_\_\_\_) \_\_\_\_ - \_\_\_\_       Work: (\_\_\_\_) \_\_\_\_ - \_\_\_\_       Cell: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
 e-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_

Spouse/Partner/Co-owner  
Name: \_\_\_\_\_

Cell: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Emergency Contact, (someone other than yourself, in case of an emergency):

Name	Phone	Relation
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If you were referred please let us know for our referral program  
Referred by: \_\_\_\_\_

**PROFESSIONAL FEES ARE TO BE PAID AT THE TIME SERVICES ARE PERFORMED**

In admitting my pet(s) for diagnostics, treatment, or surgery, I authorize the veterinarians of Animal Health Center of Land O' Lakes, Inc., and their support staff, to administer such treatment and/or perform such diagnostic or surgical procedures as deemed necessary. It is understood that an estimate of charges will be given for services upon request. No guarantee or assurance can be made as to the results that may be obtained. I realize that these charges may exceed a given estimate if complications arise. I understand that I will be contacted prior to treatment, if possible, should complications occur. I agree to pay all cost for any property damage or personal injury caused by my pet during its stay. I agree to pay all charges on the day of pickup of my pet. . If full payment has not been made, I agree to pay all cost of collection including attorney fees. Unpaid balances will accrue interest at 1.5% monthly and 18% per annum.

Signature: \_\_\_\_\_

## PATIENT REGISTRATION

Patient 1:

Dog       Cat       Other\_\_\_\_\_

Pet's Name: \_\_\_\_\_ Breed: \_\_\_\_\_

Birthdate (approx. if unknown): \_\_\_\_\_

Male    Neutered    Female    Spayed

Color/Markings: \_\_\_\_\_

Are vaccines current at this time:    Yes       No

Known history of allergies/chronic problems: \_\_\_\_\_

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Patient 2:

Dog       Cat       Other\_\_\_\_\_

Pet's Name: \_\_\_\_\_ Breed: \_\_\_\_\_

Birthdate (approx. if unknown): \_\_\_\_\_

Male    Neutered    Female    Spayed

Color/Markings: \_\_\_\_\_

Are vaccines current at this time:    Yes       No

Known history of allergies/chronic problems: \_\_\_\_\_