

New Client Registration Form

We welcome you to our practice. Please fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your pet's health.

Primary Owner's Information

First/Last Name (circle one) Ms. Mrs. Mr. Dr. _____

Email _____

Cell _____ Home _____ May we text you? Yes ☐ or No ☐

Mailing Address _____

City _____ State _____ ZIP _____

Driver's License / Identity Card _____ State _____

Are you 18 years or older? Yes ☐ or No ☐ If no, you must have an adult with you for your pet to be seen.
An adult must be the primary contact on your pet's account.

Secondary Contact Information

First/Last Name (circle one) Ms. Mrs. Mr. Dr. _____

Cell _____ Relationship to you _____

Email _____

How Did You Hear About Our Hospital? _____

If you were referred to Stone Ridge Animal Hospital by another client of ours, please specify their full name.

How would you like to receive reminders for your pet? Check all that apply.

☐ Phone Call ☐ Email ☐ Text ☐ Postcard ☐ All of the above

Patient's Information

Name _____ Date of Birth _____ Is this an estimated age? Yes ☐ No ☐

Species _____ Breed _____ Color _____ Sex _____

Spayed/Neutered: Yes ☐ No ☐ Unknown ☐ Does your pet have a microchip? _____

Please list any medications your pet is currently on or has previously been on. Include name and dosage if possible.

Previous Veterinarian Information

Clinic Name _____ Doctor Name _____

Phone Number (_____) _____ Is this a permanent transition? _____

Please read and sign the next page.

Client Agreement

I, the undersigned owner, authorized agent of the owner or good samaritan responsible for seeking veterinary care for the pet identified, certify that I am over eighteen years of age, and hereby consent to the examination of this pet by staff veterinarians at this veterinary practice. I also agree that after consultation with me, the hospital's doctors may prescribe medication for, treat, hospitalize, sedate, anesthetize and/or perform surgery on this animal. I understand that some risks always exist with anesthesia and/or surgery and that I am encouraged to discuss any concerns I have about those risks with the attending veterinarian before the procedure is initiated. Should some unexpected life-saving emergency care be required and the attending veterinarian be unable to reach me, this practice's staff has my permission to provide such treatment and I agree to pay for all related fees. **I accept that veterinary medicine is an inexact science and that no guarantee of successful treatment has been made.**

I understand that an estimate of the costs for veterinary services will be provided to me and that I am encouraged to discuss all fees attendant to such care before services are rendered and during this pet's ongoing medical treatment. If this animal is hospitalized, I agree to pay a deposit to be determined based on the estimate provided to me. I assume financial responsibility for the balance of all services rendered on a cash or credit card basis at the time the pet is discharged from the hospital. In the event the pet is hospitalized for more than twenty-four hours and the attending doctor is unable to reach me, I understand it is my responsibility to call the hospital at least every twenty-four hours to inquire as to the medical status of my pet.

If my pet is hospitalized beyond the first day at this facility, I understand that veterinary care during nighttime hours and/or weekends is provided at the discretion of the attending veterinarian. Continuous presence of personnel may not be provided during these hours. If I desire that my pet have supervision when this facility is closed, I understand my options. I may, pick up my pet and provide care in my home, in which case I accept the risks involved or have him/her transferred to a local emergency clinic where overnight veterinary supervision is available at my expense.

I further agree that either I, or an authorized agent of mine, will pick up this pet within five days after receiving written or oral notification that this animal is ready to be released from the hospital and pay for all accrued charges. Such notice will be given at the address maintained on the hospital's record. I agree that if I fail to comply with this policy, this practice may handle this abandonment in the best interests of the pet and I will be responsible for all fees incurred.

I hereby consent to receive prescription medication in child resistant containers.

I, _____, understand the veterinary client's right to receive a written prescription for the medication that can be filled by the pharmacy of my choice or my veterinarian, as provided in s. 474.224, Florida Statutes.

I hereby consent to photographic images and reproduction of images and video to be used within and/or outside *Stone Ridge Animal Hospital*.

For health reasons, if your pet is found to have fleas or ticks during any procedure that requires them to stay in the hospital, they will receive treatment with appropriate flea and/or tick product at additional cost to you.

I understand that Federal law prohibits the dispensing of certain medications including vaccinations without an examination or prescription.

I understand that payment is due at the time services are rendered.

Signature of Owner or Authorized Agent

Printed Name of Owner or Authorized Agent

Date