



Welcome to Cottage Pet Hospital!

900 E. Broadway * Anaheim, CA. 92805

Phone (714) 535-6714

www.cottagepetshospital.com

Thank you for giving us the opportunity to care for your pet. We're happy to help you with all your pets needs. To insure the best care possible, please take the time to fill in this form completely.

Thank you!

New Client Registration

Primary Owner _____ SS# _____ - _____ - _____
 Secondary Owner _____ SS# _____ - _____ - _____
 Address _____ City _____
 State _____ Zip Code _____ Home Phone (____) _____
 Primary Cell (____) _____ Work (____) _____ Employer _____
 Secondary Cell (____) _____ Work (____) _____ Employer _____
 E-Mail Address(es) _____

Please tell us how you prefer to pay your bill (Please circle one)

Cash Check Credit Card Debit Care Credit

Please note: If paying by Check, we require both a Valid Driver's License/State Issued I.D. AND Social Security Number be provided.

Driver's License/State I.D. # _____ Exp. Date _____ State _____ D.O.B. _____

How did you learn about our hospital? (Please circle one) Sign Here Previously
 Phone Book (which?) _____ Internet (which site?) _____
 Friend/Relative - If so, whom may we thank? _____

New Pet Information

Pet's Name _____ Dog or Cat Breed _____ Age _____
 Color _____ Male or Female Spayed/Neutered Microchip? Yes No
 Reason for today's visit? _____
 Previous Doctor/Hospital's name? _____ May we request records? Yes No
 What was the last kind of treatment? _____
 Previous Medical History/Treatment/Surgery _____
 Vaccination History _____
 Type of flea control? _____ Type of food? _____

I, the undersigned, owner or authorized agent of the above patient, hereby authorize the admitting veterinarian (and his designated associates or assistants) to administer such treatment as needed for the benefit of this patient. I also consent to the administration of such anesthetics as needed. I DO / DO NOT AUTHORIZE ADDITIONAL TREATMENT (IF NEEDED) SHOULD I BE UNABLE TO BE REACHED _____ (initial). I further understand that no guarantee of successful treatment is made. I also assume financial responsibility for all charges incurred to this patient, and agree to pay all such charges at the time the patient is released.

PAYMENT DUE AT TIME OF SERVICES

Signature of Owner/Agent _____ Date _____