



Adobe Animal Hospital Patient Registration Form

Welcome to Adobe Animal Hospital! Thank you for giving us the opportunity to serve your pets' medical needs. We are here for you and your pet, 7 days a week for scheduled appointments and 24 hours a day, 365 days a year for your pets' emergency medical care. Our goal is to serve both you and your pet please let us know if there is anything else we can do to make you or your pet more comfortable during your visits to our hospital.

Please fill out our registration form. Tell us about you on this side and about your pet on the other side. If you need any assistance please ask one of our veterinary receptionists.

Client Name: _____
Last First

Spouse Name: _____
Last First

Home Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Spouse Cell or Work Phone: _____

Driver License # _____

Best Email Address to Contact You: _____

How would you prefer receiving reminders for your pet's annual exams/ vaccination? Email Post Card

Are you eligible for our senior discount, age 68 or over? Yes No if yes birth date required ___/___/___

How did you hear about Adobe?

- Referred by another client - client's name: _____
- Referred by breeder or humane society Online: Yelp Google Other _____
- Yellow Pages: Book Online Read Article / Saw on T.V.
- Referred by rescue group _____ Saw building/sign on road
- Referred by another Vet _____ Referred by other pet organization _____
- www.Adobe-Animal.com

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY: This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered at the time of service. I'm also responsible for reasonable attorney's fees and costs of collection in the event of default. I further understand that if payment becomes 30 days past due, delinquency charges at the lesser of the annual rate of 18%, or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due.

Signature _____ Date _____

Please turn over to fill out your pet's information

Patient Information

	Pet #1	Pet #2
Pet Name:		
Chronic Medical Condition: Example: Diabetic/Seizures		
Species Example:		
Breed: Example: Poodle/Tabby/Finch		
Color:		
Sex:	Male Female Unknown	Male Female Unknown
Spayed/Neutered?	Yes No	Yes No
Birthdate or Approx Age:		
Microchip: Number, if Known:	Yes No # _____	Yes No # _____

YOUR PETS PREVIOUS RECORDS: If you bring in your pet's medical history, please give it to your doctor or technician. We will not scan all past medical history about your pet into our records here at Adobe Animal Hospital. Your doctor will review previous records and then make notes in your pet's medical record about serious or chronic medical conditions. Once your records have been reviewed and your doctor makes the appropriate notes, your records will be shredded for your privacy. If you would like your records returned to you, please notify your doctor or technician.

Optional

Does your pet become nervous while visiting the vet? If yes, please describe _____

Is there anything else you would like us to know about your pet? Example: Nickname? A Funny story? An interesting physical feature?

Does your pet have a preference in his/her primary doctor? If yes, please list doctor's name _____

If necessary may we contact your pet's previous veterinarian for additional information regarding your pets past medical history? If yes, please list practice name and phone number _____

For Adobe Animal Hospital Use Only

Create account: _____	Record Doctor Preference: _____
New client packet: _____	Record Vaccination Certificate: _____
Picture of pet: _____	Return Records to Client: _____