



SAHARA ANIMAL HOSPITAL REGISTRATION FORM

NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

EMAIL ADDRESS: _____

DRIVERS LICENSE # : _____ SSN: _____

CELL PHONE: _____ HOME PHONE: _____

EMPLOYER: _____ WORK PHONE: _____

CO-OWNER: _____ CELL PHONE: _____

HOW DID YOU HEAR ABOUT US? _____

PET #1:

NAME: _____ SPECIES: _____ BREED: _____

DOB: _____ SEX: _____ SPAYED/NEUTERED: _____

WHEN WAS PET LAST VACCINATED? _____

DOES YOUR PET HAVE RECORDS AT ANOTHER HOSPITAL? _____

REASON FOR VISIT: _____

PET #2:

NAME: _____ SPECIES: _____ BREED: _____

DOB: _____ SEX: _____ SPAYED/NEUTER: _____

WHEN WAS PET LAST VACCINATED? _____

DOES YOUR PET HAVE RECORDS AT ANOTHER HOSPITAL? _____

REASON FOR VISIT: _____

*I HEREBY AUTHORIZE THE VETERINARIAN TO EXAMINE, PRESCRIBE FOR, OR TREAT, THE ABOVE DESCRIBED PETS. I ASSUME RESPONSIBILITY FOR ALL THE CHARGES INCURRED IN THE CARE OF THIS ANIMAL. I UNDERSTAND THAT THESE CHARGES WILL BE PAID AT THE TIME OF RELEASE AND THAT A DEPOSIT MAY BE REQUIRED.

A SERVICE CHARGE OF \$10 AND AN INTEREST CHARGE OF 2% PER MONTH WILL BE APPLIED TO ALL PAST DUE ACCOUNTS UNTIL PAID

IF THE BANK RETURNS A CHECK PAYMENT YOU WILL BE CHARGED A RETURN CHECK FEE

IF YOUR ACCOUNT IS TURNED OVER TO COLLECTIONS YOU AGREE PAY ALL COLLECTION EXPENSE, INCLUDING ATTORNEY'S FEES, COURT COSTS, FILING FEES, AND ANY COLLECTION AGENCY FEES

SIGNATURE OF OWNER OR AGENT: _____ DATE: _____

