



VETERINARY  
SPECIALTY  
CENTER

## CLIENT REGISTRATION FORM

VETERINARY SPECIALTY CENTER  
1515 Busch Parkway, Buffalo Grove, IL 60089  
(847) 459-7535

Have you ever been to this hospital before?  Yes  No

Primary Owner's Name: \_\_\_\_\_  
LAST FIRST MIDDLE

Address: \_\_\_\_\_ Apt / Suite #: \_\_\_\_\_

CITY STATE ZIP

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

E-Mail: \_\_\_\_\_

Co-Owner's Name: \_\_\_\_\_  
LAST FIRST MIDDLE

Address (if different): \_\_\_\_\_ Apt / Suite #: \_\_\_\_\_

CITY STATE ZIP

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

### PET INFORMATION

Name: \_\_\_\_\_ Species (circle one): DOG CAT Breed: \_\_\_\_\_ Color: \_\_\_\_\_

Sex: (circle one) Female Male  
Female Spayed Male Neutered Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Weight: \_\_\_\_\_

Please provide the following information so that we may ensure that your hospital records are forwarded to your regular veterinarian:

Hospital/Clinic: \_\_\_\_\_ Referring Veterinarian: \_\_\_\_\_

Do you have a secondary veterinarian (such as an emergency hospital) who referred you here today?

Hospital/Clinic: \_\_\_\_\_ Referring Veterinarian: \_\_\_\_\_

- I hereby authorize the doctor and assistants to administer treatment as is considered therapeutically and/or diagnostically necessary. I authorize medical treatment, as well as possible alternate modes of treatment, as explained to me by the doctor. I further authorize surgical procedures of an emergency nature, if deemed necessary.
- I give my permission to release case/patient information and/or photos so they may be used in teaching, continuing education, website, veterinary literature, and the like. Patient confidentiality will be maintained.
- I consent to release all above medical information to Veterinary Specialty Center, Surgical Referral Service, Veterinary Medical Referral Service, Midwest Veterinary Dermatology Center, VSC Emergency & Critical Care, TheraPET Wellness Center and /or Imaging Center for Animals.
- I assume full financial responsibility for all charges incurred for the care and treatment of this patient, regardless of outcome. I further understand that if I fail to pay the entire amount, a monthly service fee of 2% will be added to any unpaid balances. If legal action is instituted to collect the unpaid balance, I agree to pay all costs for collections, late fees, legal expenses, service fees and attorneys' fees.
- I certify that I am at least 18 years of age and have the authority to make decisions on behalf of the patient.

Owner/Agent Signature \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ AM / PM \_\_\_\_\_  
Date Time Staff Initials