



CLIENT REGISTRATION FORM

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

CLIENT INFORMATION

Have you ever been to this hospital before? Yes No

Primary Owner's Name: _____
TITLE LAST FIRST MIDDLE

Spouse's/Emergency Contact Name: _____
LAST FIRST MIDDLE

Address: _____ Apt / Suite #: _____

CITY STATE ZIP COUNTY

Home Phone: (____) _____ Owner's Work Phone: (____) _____ E-Mail: _____

Cell/Pager: (____) _____ Spouse's/Emergency Contact's Work Phone: (____) _____

Employer: _____ Phone: (____) _____ Ext: _____

SOCIAL SECURITY # DRIVERS LICENSE # STATE OF DL BIRTH DATE / /

PET INFORMATION

Name: _____ Species (circle one): CANINE / FELINE Breed: _____ Color: _____

Sex: (check one): Female Female Spayed Male Male Neutered
Weight: _____ Date of Birth (MM/DD/YY): ____/____/____

In order for us to provide you with the best continuity of care, 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? If so, please provide their information here:

Hospital/Clinic: _____ Referring Veterinarian: _____

In the last year, has your pet been vaccinated against: Answer YES or NO or UNKNOWN

- | | | |
|----------------------------|---|---------------------|
| BOTH | CATS | DOGS |
| _____ Rabies | _____ Feline Leukemia Virus (FeLV) | _____ Leptospirosis |
| _____ Distemper | _____ Feline Immunodeficiency Virus (FIV) | _____ Lyme Disease |
| _____ Heartworm Prevention | _____ Feline Infectious peritonitis (FIP) | _____ Parvovirus |

Has your pet ever had any adverse drug reaction(s)? ____ If yes, to what medication(s)? _____

Does your pet currently have any contagious conditions? Yes No If yes, explain: _____

Is your pet currently on any prescription or over-the-counter medications(s)? If yes, please list the drug(s) and dosage(s): _____

LIST REASONS/SYMPTOMS THAT BROUGHT YOUR PET HERE TODAY AND WHEN THEY FIRST APPEARED:

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 assume full financial responsibility for all charges incurred for the care and treatment of this patient. I further understand that if I fail to pay the entire amount, a monthly service charge of 2% will be added to any unpaid balances over 30 days. If my account is turned over to a collection agency, I agree to pay 33.33% of the unpaid balance as collection fees in addition to the principle amount owed. I further agree to pay reasonable attorney fees and court costs arising out of any litigation concerning the collection of this account. I hereby authorize the collecting practice to obtain credit reports on me.

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 Imaging Center for Animals.

Owner/Agent _____ Date ____/____/____ Time _____ AM / PM Staff Initials _____