VETERINARY SPECIALTY HOSPITAL

Client Registration Form

San Diego | San Marcos

CLIENT INFORMATION:

Client Name: _____ **Phone:** _____ ◯ Home ◯ Cell ◯ Work

Address: _____ **City/Town:** _____

State: _____ **Zip:** _____ **Email:** _____

Co-Owner Name: _____ **Co-Owner Phone:** _____ ◯ Home ◯ Cell ◯ Work

Co-Owner Email: _____

Mark all that apply:

◯ Active Military/Veteran *(with valid ID)*
◯ Service Dog *(with proof of formal training)*
◯ Military/Police Animal
◯ Rescue Group/Shelter *(with valid documentation)*
◯ Veterinarian
◯ Veterinary Staff Member

I/We grant permission to the hospital medical team to text reminders and updates to the mobile number(s) provided ◯ Yes ◯ No

Owner Date of Birth: _____ **Co-Owner Date of Birth:** _____

State Guidelines require that the caregivers' dates of birth be recorded when distributing controlled medications.

PATIENT INFORMATION:

Patient Name: _____ **Age/Date of Birth:** _____

Breed: _____ **Species :** ◯ Dog ◯ Cat **Sex:** ◯ Neutered Male ◯ Intact Male ◯ Spayed Female ◯ Intact Female

Color: _____

Pet Insurance Carrier: _____ **Pet Insurance Number:** _____

REFERRING VETERINARIAN INFORMATION:

Primary Care Veterinarian: _____

Primary Care Veterinary Hospital: _____

Location (*City/State*): _____ **Phone:** _____

SOCIAL MEDIA PHOTO RELEASE:

◯ I GRANT ETHOS PERMISSION ◯ I DO NOT GRANT ETHOS PERMISSION

With your permission, if circumstances are appropriate, we may take photos of your pet for marketing or educational purposes. We do not share personal information including your last name, confidential medical information and communications with your veterinarian. We may identify you and your pet by first name.

I grant permission and acknowledge and agree that no sums whatsoever will be due to me as a result of their use.

CONSENT: I have read and agree to the policies below

I consent to an examination of my pet by the providers at this Ethos Veterinary Health hospital. I understand that diagnostics and treatment along with the associated costs will be discussed with me prior to delivery and I have the right to decline. If my pet is hospitalized, I understand the provider will present an estimated treatment plan with the associated costs, however, treatment may vary throughout the duration of my pet's stay. I will be informed of any costs that exceed the initial treatment plan so I am able to make informed decisions about my pet's care.

Payment is due at the time of service and any remaining balance must be paid when services are complete. All day services and hospitalizations require a deposit in full of the estimated cost.

I understand that photos for marketing or educational purposes may be taken of my pet, if circumstances are appropriate. Personal information is not shared including last name, confidential medical information and communications. My pet and I may be identified by first name. I grant permission and acknowledge and agree that no sums whatsoever will be due to me as a result of the use.
I understand that a photograph of my pet for identification purposes is captured and stored in the medical record. This is used identification and is not shared. This photo is compulsory as it ensures proper care for your pet while in our care.

Signature: _____ **Date:** _____