

WEST VALLEY ANIMAL HOSPITAL, LLC REGISTRATION

Date _____ Pet Insurance Provider _____

Owner's Name _____ Email address _____

Home phone _____ Cell phone _____ Work phone _____

Spouse/Other _____ Email address _____

Cell phone _____ Work phone _____

Address _____ City _____ State _____ Zip _____

Please check preferred contact methods: Home ___ Cell ___ Email ___ Mail ___ Text ___ (Cell carrier ___)

Please list all persons over 18 years of age authorized to make treatment decisions for your pets in your absence:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Pet's Name _____ Birth date or age _____ Dog ___ Cat ___ Other _____

Male ___ Female ___ Neutered? ___ Breed _____ Microchip? ___

Previous veterinarian where records can be obtained _____

Other pets:

Name _____ Breed _____ Age _____ Sex _____ Neutered? _____

Name _____ Breed _____ Age _____ Sex _____ Neutered? _____

Name _____ Breed _____ Age _____ Sex _____ Neutered? _____

How did you hear of us?: Drive by? _____ Web site (which one?) _____

If a referral from an individual, please list the name for us to thank _____

I grant permission for West Valley Animal Hospital, LLC its employees and agents to take and use video/audio images of my pet(s). Video/audio images include any type of recording, including but not limited to: photographs, digital images, video recordings, audio recordings or accompanying written descriptions. I agree that West Valley Animal Hospital, LLC owns the images and all rights related to them. I give permission for the images to be used in any manner, including hospital - sponsored web sites, publications, promotions, broadcasts, advertisements and posters, without prior notification. I waive any right to inspect or approve the finished images or any printed or electronic matter that may be used with them or to be compensated for use of the images. **Please initial here to give your permission** _____

I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be due at the time services are rendered and that a deposit may be required for surgical or hospital treatment.

Owner or agent's signature _____

We accept cash, PA first party checks, Mastercard, Visa, Discover, American Express and Care Credit