Welcome

to Michigan Road Animal Hospital @ Crooked Creek

Thank you for giving us the opportunity to care for your pet. We'll be happy to answer any questions you have about your pet's health. To ensure the best care possible, please take the time to fill in this form completely. Thank You!

REGISTRATION

Date _____

Owner's Name _____ **Social Security Number** _____-_____-_____

Address: Street _____ **Apt #** _____

City _____ **State** _____ **Zip** _____

Additional Owner _____ Social Security Number _____-_____-_____

Cell Phone _____ **Home Phone** _____ **Other Phone** _____

Please circle the phone number we should list as your primary phone number.

Employer: _____ **Work Phone** _____

Date of Birth (responsible party must be 18 years old) _____

By providing us with your e-mail you'll get access to a Pet Portal at www.ccahvets.com as well as e-mails from us.

E-mail:_____**@** _____ **E-mail declined** _____

*For your convenience, please provide your Drivers License number. This will alleviate future requests each time you pay by check.

Driver's License Number* _____ State Issued _____

Were you referred to us by a current client? If so, we would like to send them a Thank You! _____

If not, we would like to know how you found out about us? _____

If we take a picture of your pet, do we have your permission to use it on our social media sites? Yes No

PET(s) HEALTH HISTORY

NAME OF PET(s)	BREED	COLOR	BIRTHDATE	M/F	SPAYED or NEUTERED?	IS YOUR PET MICROCHIPPED?

If you have previous medical history and you brought it with you today, thank you! We would like to make a copy of it to complete your pet's record with us.

Are any of your pet(s) on any medications or supplements? _____

_____

Has your pet(s) ever had a reaction to vaccines or medications? _____

Does your pet(s) have any known allergies? _____

Is there anything else you'd like to share with us about your pet(s)? _____

Do you have pet health insurance? If so, with what company?_____

AUTHORIZATION

I hereby authorize the Doctors and staff of Michigan Road Animal Hospital to provide medical service to my pet(s), and I assume full financial responsibility, understanding that services are to be paid for at the time of release of my pet. I also understand that a deposit may be required for some surgical services and/or treatments. Any fees associated with an overdue account: interest charges allowed at the current legal rate, late fees, collections agencies costs, attorney fees, & court costs are my responsibility. The charge for a returned check is $35.00. Returned checks may be turned over to the Marion County Bad Check Program.

Your privacy is important to us. All personal information received is subject to our Patient Privacy Policy.

We would be more than happy to give you a detailed estimate prior to your pet being seen. Please let us know!

Signature of Owner _____ (Responsible party must be 18 years old)

Payment Options Accepted: Cash Check Mastercard Discover Visa Care Credit