



# New Client-Patient Registration & Financial Policies

Thank you for giving us the opportunity to care for your pet.  
So that we may best serve you, please complete the following:



OWNER #1: \_\_\_\_\_

Title                      First    M.I.    Last Name

OWNER #2: \_\_\_\_\_

Title                      First    M.I.    Last Name

CHILDREN (OPTIONAL): \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Number and Street    City

State    Zip Code

Should we need to contact you, please indicate your preference:    (circle one)    **Email**    **Text**    **Phone**

€ E-MAIL ADDRESS(es): \_\_\_\_\_

€ RESIDENCE PHONE(S): \_\_\_\_\_

€ CELL PHONE: \_\_\_\_\_

OWNER #1 PLACE OF EMPLOYMENT: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

OWNER #2 PLACE OF EMPLOYMENT: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

HOW DID YOU BECOME AWARE OF OUR HOSPITAL? Please check all that apply.

€ I was referred by a friend ~ Whom may we thank? \_\_\_\_\_

€ Drive by    € Our website/Internet    € Facebook    € Twitter    € Google+    € Bing    € Yelp

CONTACT PERSON IN CASE OF EMERGENCY: Name: \_\_\_\_\_

Phone Number (with area code): \_\_\_\_\_ Relationship to Owner: \_\_\_\_\_

## **FINANCIAL POLICY**

Balboa Pet Hospital requires payment in full at the end of your pet’s examination and/or at the time of discharge. Our primary mission is to deliver the best client service and the most comprehensive veterinary care available for your pet. An important part of this mission is making the cost of optimal care as easy and manageable for our clients as possible by offering several payment options. For some treatments or hospitalized care, a deposit may be required. Treatment plans requiring comprehensive care of more than \$500 will require a 50% deposit to begin your pet’s treatment. Our Payment options include:

**CASH                      CHECK                      DEBIT                      VISA                      MASTERCARD                      DISCOVER**

**CARECREDIT:** 6 months Interest Free Financing with convenient monthly payment plans, allow you to begin treatment today and pay over time. Available for any treatment amount and can be used for any of your entire family’s medical needs, without having to reapply. We can assist you with the application process. Go to: [www.carecredit.com/apply](http://www.carecredit.com/apply) for more information.

**INSURANCE:** We encourage our clients to use pet insurance and recommend Trupanion Pet Insurance, which covers unexpected pet health expenses and recently added coverage for Prescription Diets and some dental care. We are happy to assist you with documentation for a claim with any carrier.

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**PET INFORMATION**

Please fill in the appropriate information for each pet you own.

	<b>PET #1</b>	<b>PET #2</b>	<b>PET #3</b>
NAME			
SPECIES: Cat, Dog, Other			
BREED			
COLOR			
DATE OF BIRTH			
AGE WHEN OBTAINED			
OBTAINED FROM AND WHEN			
CURRENT DIET (Brand name)			
SEX			
LIFESTYLE : INDOOR, IN/OUT			
SPAYED OR NEUTERED?	Circle One <b>Y N</b>	Circle One <b>Y N</b>	Circle One <b>Y N</b>
MICROCHIPPED?	Circle One <b>Y N</b>	Circle One <b>Y N</b>	Circle One <b>Y N</b>
ON HEARTWORM PREVENTION?	Circle One <b>Y N</b>	Circle One <b>Y N</b>	Circle One <b>Y N</b>
ON SYSTEMIC FLEA CONTROL?	Circle One <b>Y N</b>	Circle One <b>Y N</b>	Circle One <b>Y N</b>

I authorize the following individuals to present the above-named, and any future pets, for treatment. Must be over 18 years of age.

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 \_\_\_\_\_

I give my permission to obtain previous health records. NAME OF PREVIOUS VETERINARIANS WHERE RECORDS CAN BE OBTAINED: \_\_\_\_\_

**TO PREVENT THE SPREAD OF INFECTIOUS DISEASES AND PARASITES, HOSPITALIZED AND BOARDED ANIMALS MUST BE CURRENT ON ALL VACCINES AND FREE OF INTERNAL AND EXTERNAL PARASITES. I AUTHORIZE THE DOCTOR TO PROVIDE VACCINES AND PARASITE CONTROL AS NEEDED FOR MY PET.**

**VETERINARY SERVICE IS PROVIDED DURING NIGHT TIME HOURS ONLY AS NECESSARY IN THE JUDGMENT OF THE VETERINARIAN IN CHARGE.**

**BY SIGNING BELOW YOU AGREE TO THE FOREGOING TERMS OF PAYMENT AND ASSUME RESPONSIBILITY FOR ALL CHARGES INCURRED IN THE CARE OF YOUR PET(S), AGREEING THAT THESE CHARGES WILL BE PAID AT THE TIME OF RELEASE AND THAT A DEPOSIT MAY BE REQUIRED FOR TREATMENT. I GIVE PERMISSION TO BALBOA PET HOSPITAL TO OBTAIN MEDICAL RECORDS FROM MY PREVIOUS VETERINARIAN.**

\_\_\_\_\_  
 Owner #1 Signature

\_\_\_\_\_  
 Today's Date

\_\_\_\_\_  
 Owner #2 Signature

\_\_\_\_\_  
 Today's Date