WEST VALLEY ANIMAL,LLC HOSPITAL 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