



SOUTHERN CALIFORNIA
VETERINARY SPECIALTY HOSPITAL

OWNER/PATIENT REGISTRATION

CLIENT ID : _____ :

PATIENT ID : _____ :

OWNER'S INFORMATION:

Today's Date: / /

Owner's Last Name:	First Name:	Owner's Date of Birth:
Co-Owner/Spouse Full Name:	Other authorized persons:	<input type="checkbox"/> auth. to make decisions <input type="checkbox"/> auth. to pick up/receive updates
Address	City	State Zip Code
Employer	Occupation	
Phone Numbers: Please list any additional phone numbers here:		
(____) _____ - _____	:	_____
(____) _____ - _____	:	_____
(____) _____ - _____	:	_____

PET'S INFORMATION:

Pet's Name:		Pet's Date of Birth:	
Species:	Breed:	Sex:	Pet's Disposition: <input type="checkbox"/> Friendly <input type="checkbox"/> Painful, may bite <input type="checkbox"/> Approach with Caution <input type="checkbox"/> Animal Aggressive
	Color:	Weight:	

Presenting Complaint:

Known Allergies:

Current Medications:

REFERRING VETERINARIAN INFORMATION:

yes no May we request your Pet's Health Records?

Primary Veterinarian	Clinic Name:
Address	City State Zip Code
Phone	Fax

2nd Veterinarian	Clinic Name:
Address	City State Zip Code
Phone	Fax

ACCOUNT INFORMATION:

Who is responsible for this account? <input type="checkbox"/> Owner/Co-Owner	Driver's License No.	Exp. & State	Soc. Sec. No.
other: (Optional) Credit Card #	Credit Card Exp. Date	Billing Zip Code	V-Code

Authorized Signature for Credit Card use



SOUTHERN CALIFORNIA
VETERINARY SPECIALTY HOSPITAL



IRVINE REGIONAL ANIMAL
EMERGENCY HOSPITAL

**Southern California Veterinary Specialty Hospital
&
Irvine Regional Animal Emergency Hospital
Authorization for Examination / Treatment**

Owner:

Responsible Party: _____
(if different than listed above)

Patient:

I, the undersigned, owner or authorized agent of the admitted patient, hereby authorize the admitting veterinarian (and his/her designated associates or assistants) to administer such treatment as is necessary to perform procedures considered therapeutically and/or diagnostically necessary. I also consent to the administration of such anesthetics as are necessary.

I further understand that no guarantee of successful treatment is made, and that the risks and probabilities of complications exist with any surgical or medical treatment.

I understand that charges are incurred for the services rendered, and that payment for such services is due and payable at the time they are rendered, or prior to discharge of the animal from the hospital.

Any animal not picked up within the time required by section 1843 of the California Civil Code shall be deemed abandoned by the Owner and will be disposed of according to Section 1834.5 and 1834.6 of the California Civil Code.

I understand that this action will not, however, relieve from paying all accrued charges, and all legal and/or court costs incurred in connection with collection of such charges.

Date Signature of Owner or Responsible Party

Our hospital offers a senior discount (excluding CERF exams). However, due to our large clientele it is the responsibility of our clients to make sure any discounts are applied at the time of check out.

1371 Reynolds Avenue
Irvine, CA 92614
T 949-833-9020 F 949-833-7530

WWW.PETSURGERY.COM



OUR POLICY OF CARE AND PAYMENT

Ensuring that our patients receive high quality care is the goal of our practice.

Payment is due at the time of treatment. We accept cash, *check, and major credit cards. We also have a payment plan called CareCredit, that allows you to start treatment today and spread payments over time (**some plans offer no interest).

Payment Options

1. **Cash**
2. **Check** (*electronically processed – signer of check must be present)
3. **Major Credit Cards** (Visa, MasterCard, Discover, American Express)
If card holder is not present – we must obtain verbal authorization & certain security questions
4. **CareCredit** (Subject to credit approval) If credit application is declined, another form of payment listed above is required.

CareCredit:

- Applying for CareCredit only takes a few minutes and there is no fee to apply. Please inquire with the front desk for details.
- **Promotional offers of 6 and 12 Month No Interest Payment Plans & 24,36,48,and 60 Month Extended Payment Plans are available.
- Account holder must be present to sign sales receipts for all CareCredit transactions.

Client ID:

:
Client Name / Responsible Party (print name if not listed above)

Signature of Client / Responsible Party

Date