

Welcome to Miramar Animal Hospital
Thank you for allowing us to care for your pet(s)!

Client (Owner) Information

Dr. Mr. Mrs. Ms. _____
(Circle One)

Street Address: _____ Apt # _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address (Please print clearly): _____

Spouse or Co-Owner: _____ Contact # _____

Emergency Contact: _____

How did you hear about us? _____

Who can we thank for the Referral? _____

Owner Date of Birth: _____

Patient Information:

Name: _____ Please Circle: Feline / Canine

Breed: _____ Female / Male Spayed / Neutered

DOB: ____/____/____ Estimate Age (if DOB unknown): _____

Color & Markings: _____

Does your pet have any re-occurring, or significant medical history? YES / NO

Explain Briefly: _____

Does your pet have a microchip? YES / NO

Is your pet on medications? YES / NO

List: _____

Financial Policy Summary: We ***do not*** bill for services. In-patient care is written consent. Payment is due in full at the time that services are performed. We accept CASH, VISA, MASTERCARD, AMEX, DEBIT, CARECREDIT and CHECK payments.

I have read, understood, and agree to the Financial Policy.

Signature: _____ **Date:** _____