BEVS
24/7 ER/SPECIALTY CARE

REGISTRATION FORM

Internal Medicine | Emergency | Surgery | Oncology
Rehabilitation + Acupuncture

CLIENT INFORMATION

Primary Veterinarian: _____ Primary Animal Hospital: _____

Pet Owner: _____ Primary Phone: _____ Email: _____

Co-Owner: _____Primary Phone: _____ Email: _____

Alternative Contact Numbers: _____ _____ _____

Mailing Address: _____
P.O. Box / Street City/Town State Zip Code

PLEASE CIRCLE:

Are you **18** years of age or older: YES NO

Form of payment: VISA MASTERCARD DISCOVER AMERICAN EXPRESS CASH CHECK CARE CREDIT

How did you hear about us: VETERINARIAN FRIEND WEB YELLOW PAGES OTHER: _____

PET INFORMATION

Reason for Visit: _____

Name: _____ Dog ☐ Cat ☐ Other: _____

Breed: _____Color: _____ Male / Female / Unknown Spayed / Neutered: Y / N

Date of Birth / Age: _____ Current Medications: _____

I assume responsibility for the above described pet and hereby authorize the veterinarian to examine, prescribe for, and provide treatment as deemed necessary for the health, safety, or well-being. I assume responsibility for all charges incurred in the care of this animal regardless of outcome. I also understand that these charges will be paid at the time of release and that a deposit may be required prior to treatment. I will be responsible for any fees incurred by BEVS in the process of collecting my balance.

_____ _____

Signature of Owner or Agent ***Date***

A 50% DEPOSIT MAY BE REQUIRED PRIOR TO TREATMENT WITH BALANCE DUE AT DISCHARGE