Albany Animal Hospital, Inc.
Client Registration Form

Name_____
Last First MI

Nickname_____ Date of Birth_____

Marital Status: Single / Married / Divorced

Address_____
Street City State Zip

Mailing Address if different from above:

_____

Home Phone_____ Cell Phone _____ Ok to Contact via Cell? Yes / No

Best time to reach me is: _____

E-Mail Address_____

Driver's License/ID #_____ State_____

Occupation_____ Employer_____ Work #_____

Emergency Contact_____ Emergency Phone # _____

Spouse / Co-Owner Name_____
Last First MI

Nickname_____ Date of Birth_____

Address_____
Street City State Zip

Mailing Address if different from above:

_____

Home Phone _____ Cell Phone _____ Ok to Contact via Cell? Yes / No

E-Mail Address_____

Driver's License/ID #_____ State_____

Occupation_____ Employer_____ Work #_____

If a third party is paying for service, they will need to fill out a separate registration form with their information.

How did you find us? ☐ Dex ☐ Facebook ☐ AAH Website ☐ Yellowbook ☐ Street Sign
☐ Other _____

☐ I was referred by _____

Pet #1

Name_____ Dog ___ Cat___ Other_____ Birthdate/Approx. Age_____
Male___ Female___ Altered? Y / N Breed_____ Color _____
Clinic(s) Previously Seen At _____
Current Medications_____

Pet #2

Name_____ Dog ___ Cat___ Other_____ Birthdate/Approx. Age_____
Male___ Female___ Altered? Y / N Breed_____ Color _____
Clinic(s) Previously Seen At _____
Current Medications_____

Pet #3

Name_____ Dog ___ Cat___ Other_____ Birthdate/Approx. Age_____
Male___ Female___ Altered? Y / N Breed_____ Color _____
Clinic(s) Previously Seen At _____
Current Medications_____

Pet #4

Name_____ Dog ___ Cat___ Other_____ Birthdate/Approx. Age_____
Male___ Female___ Altered? Y / N Breed_____ Color _____
Clinic(s) Previously Seen At _____
Current Medications_____

I hereby authorize AAH, Inc. and the veterinarian to examine, prescribe for, and treat the above described pets. I assume complete responsibility for all charges incurred in the care of this animal. I understand that these charges must be paid at the time of release and that a deposit may be required for surgical treatment or hospitalization. I understand Care Credit is the ONLY FORM OF A PAYMENT PLAN available.

A service charge of 2% per month or $5 per month, whichever is greater, will be charged on all past due accounts. In the event suit or other action is required to collect this account, the prevailing party shall be entitled to recover all costs incurred in collecting said past due account, including but not limited to reasonable attorney fees at both the trial and appellate levels.

I understand and agree, if there are any disputes regarding products sold or services provided, I must address them in person or in writing within 7 days of the product purchase or service date.

Signature of Owner or Agent_____ Date_____

Printed Name_____

Signature of Co-Owner/Spouse_____ Date_____

Printed Name_____

Method of Payment (Please circle one) Cash Credit / Debit Card Care Credit

PLEASE BE AWARE WE ARE NOT ABLE TO TAKE CHECKS AS PAYMENT FROM FIRST TIME CLIENTS & WE DO NOT ACCEPT AMERICAN EXPRESS

Thank you for your understanding in this matter.