TIMBERVIEW PET CLINIC, P.A. **CLIENT REGISTRATION No. _____**

Name _____Home Phone_____
LAST FIRST MIDDLE
Cell Phone _____

Address _____
STREET APT. NO. CITY STATE ZIP

Email Address: _____
(To be used for sending Timberview related information ONLY i.e. newsletters, etc. We will not disclose to 3rd parties)

Occupation _____Employer _____ Work Phone _____

Spouse or Co-owner's Name

_____
LAST FIRST MIDDLE

Occupation _____Employer _____ Work Phone _____

Cell Phone _____

Referred by _____
(Name of persons, yellow pages, signs, ad, etc.)

YOUR PETS Name of Pet Species

_____

_____

_____

_____

_____

I hereby authorize Timberview Pet Clinic to examine, prescribe for, treat or perform surgery upon the pet(s) listed above. I also consent to the administration of such tranquilizers/anesthetics as are deemed necessary.

I understand that while all procedures will be performed to the best abilities of the clinic's staff. No guarantee or warranty can be made regarding the result or cure.

I hereby accept financial responsibility for all services rendered. I understand that payment is due in full at the time service is rendered. I understand that fee payment will be required in advance for hospitalized pets.
A $35.00 Service Charge will be charged for all returned checks.

The following information is required:

Florida Driver's License No. _____ Date of Birth _____

Height _____ Race _____ Sex _____

Signature of Owner or Agent _____ Date _____