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

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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 $30.00 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 __________________