

# Advanced Veterinary Dental Surgery



Please:

1. complete the new patient registration form
2. present the completed form to our receptionist when you arrive
3. contact your primary care veterinarian to request your pet's medical records

<b>Owner(s) Name</b>				
Address		City	State	Zip Code
Primary phone	Emergency phone		E-mail	

Does anyone else have permission to make decisions on behalf of your pet?

<b>Name</b>				
Address		City	State	Zip Code
Primary phone	Emergency phone		E-mail	

I understand that payment in full is due at the time of service. I agree to assume financial responsibility for all professional fees, and agree to pay AVDS when services are rendered. I understand that a fee of 1.5% will be charged on any unpaid balance. AVDS may also recover reasonable attorney's fees and court costs incurred as a result of my failure to pay in accordance with this authorization.

<b>Owner signature:</b>	<b>Date:</b>
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<b>Pet Name</b>	Date of birth	Dog or Cat?	
Breed	Color	Male or Female? Intact or Neutered?	
Medications	Vaccination status	FeLV/FIV status	Heartworm status

<b>Primary care hospital</b>	Name: Address:
<b>Primary veterinarian</b>	
<b>Referring veterinarian (if different from primary)</b>	

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