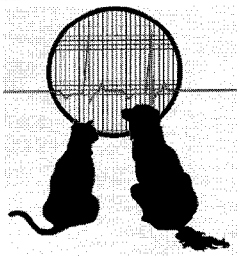

Broadway Animal Hospital

by the Bay

CLIENT FORM

Primary Owner Name:_____ **Date:** _____

Owner/Agent must be 18 years or older

Mailing Address: _____

City:_____ **State:**_____ **Zip Code:**_____

Physical Address *(if different)*: _____

Primary Phone #: _____ **Secondary Phone #:**_____

Email address:_____

If we are unable to leave a voicemail message, we will contact you via email.

Driver's License #: _____ **Exp. Date:**_____ **DOB:**_____

Additional Owner Name:_____ **Phone #:**_____

Are they authorized to make medical decisions/update contact information? Yes No

In addition to the persons listed above, the following people have authority to make medical decisions for all pets listed on my file, up to and including spaying, neutering, and euthanasia.

1._____

2._____

**All additional authorized persons must be 18 years or older*

Discount Eligibility

Are you over the age of 65? Yes No Are you US Military? Yes No Veteran? Yes No

Patient Information

Name:_____

Species: Canine Feline Exotic:_____

D.O.B/Age:_____ **Sex:** Male / Neutered Female / Spayed

Breed:_____ **Primary Color:**_____

Previous Veterinary Hospital: _____

Date of last vaccines:_____

Is your pet currently on any medications? Yes No

If yes, what medications? _____

What is the reason for your visit today? _____

Additional Patient Information

Name:____

Species: Canine Feline Exotic:__________________

D.O.B/Age:______________ **Sex:** Male / Neutered Female / Spayed

Breed:__________________________ **Primary Color:**____________________

Name:____

Species: Canine Feline Exotic:__________________

D.O.B/Age:______________ **Sex:** Male / Neutered Female / Spayed

Breed:__________________________ **Primary Color:**____________________

Name:____

Species: Canine Feline Exotic:__________________

D.O.B/Age:______________ **Sex:** Male / Neutered Female / Spayed

Breed:__________________________ **Primary Color:**____________________

Name:____

Species: Canine Feline Exotic:__________________

D.O.B/Age:______________ **Sex:** Male / Neutered Female / Spayed

Breed:__________________________ **Primary Color:**____________________

Name:____

Species: Canine Feline Exotic:__________________

D.O.B/Age:______________ **Sex:** Male / Neutered Female / Spayed

Breed:__________________________ **Primary Color:**____________________

Broadway Animal Hospital does not do any billing; Payment is due in full at the time of service- no exceptions. We accept cash, Visa, Mastercard, Discover or Care Credit. We do not accept checks from new clients. We charge a fee of $25 for any returned checks from established clients.
I understand that I will be expected to provide payment today for all services provided. Initials_____

Rabies Certificate
I understand that in accordance with Humboldt County Ordinance Code Section 542-5, Broadway Animal Hospital provides a duplicate copy of canine rabies certificates to the Humboldt County Animal Shelter.
Initials _____

Cancellation/No Show Policy
Our commitment to provide the best care to all our patients is our first priority. We understand that situations may arise that may require you to postpone or cancel your pet's appointment. Please understand these situations affect both the doctor's time as well as other possible patients. This time can be reallocated to someone who is in need of treatment, if the required notice is provided as outlined below.

We ask that you notify our office if you need to cancel or reschedule your pet's appointment at least 24 hours prior to your scheduled appointment.

Please note that if your appointment is scheduled in the morning you MUST call our office by 5pm the night before your scheduled appointment. Failure to do so will result in a cancelled appointment without the proper notification and you will be charged a fee of $25.
I have read the above and understand the Cancellation/No Show Policy. Initials_____

I will bring my dog in on a leash and my cat in a secure carrier. If you do not have a leash or carrier, please let us know as we can lend one for your visit. **Initials_____**

I will leave my pet in the car if he/she is displaying any of the following symptoms:
*Vomiting *Diarrhea *Coughing *Sneezing **Initials_____**

I understand *a drug shall not be prescribed for a duration inconsistent with the animal(s) medication condition or type of drug prescribed. The veterinarian shall not prescribe a drug for a duration longer than one year from the date the veterinarian examined the animal(s) and prescribed the drug.* [California code of Regulations. Title 16, Section 2032.1. Business and Professions Code Section 4051]

Initials_____

Signature of Owner/Agent: _____ Date: _____
By law we are required to maintain accurate client and patient information and verify information on a regular basis. This form needs to be fully completed and we will periodically be required to update this form.