Acct# _____

414 E. Carrillo Street, Santa Barbara, CA 93101
PH (805) 729-4460 FAX (805) 965-8387
www.avs4pets.com

New Patient Registration

Owners Last Name	First Name	MI	Second Name on Account & Relationship
			Circle One: Spouse / Partner / Relative / Friend / Pet Sitter

Street Address (with Apt/Lot No. & Zip Code)	Mailing Address (if different than street)
Apt/Lot:	Apt/Lot:
City: Zip:	City: Zip:

Phone Numbers	Phone Numbers for Second Name
Primary:	Primary:
Secondary:	Secondary:
Tertiary:	Tertiary:

Client Drivers License (For CURES reporting)	Client Date of Birth (For CURES reporting)
State: Number:	

Occupation	E-Mail:	Join Mailing List?
		Yes / No

Owner Preferences	
Please remind me of upcoming appointments by: Circle One: Email / Phone / Both	May we post pictures of your pet on the web? Circle One: Yes / No
Preferred Pharmacy?	
How did you learn about our hospital (Circle One)? Drove By / Friend or Relative / Referred by Vet / Website / Yelp Other (specify): _____ Who may we thank for your referral? _____	

Pet's Name	Dog/Cat/Other	Breed	Sex	Spay/Neuter	DOB/Age	Color

Has your pet ever bitten anyone? Yes / No	Is your Pet taking medications or on a special diet? Yes / No
Clinic & Veterinarian who last gave your pet vaccinations: Please enter "None" if your pet has never been vaccinated.	Clinic & Veterinarian who last saw your pet: Has your pet ever had an allergic reaction? Yes / No

Authorization To Provide Care

I confirm I am 18 years old (or older) and I am the owner (or authorized agent of the owner) for the pet(s) listed above. With my signature, I authorize the veterinarians and staff of Advanced Veterinary Specialists to examine, treat, administer medications, and perform diagnostic, surgical procedures, and/or to hospitalize my pet if the doctor(s) deem it necessary for the health, safety or well being of my pet. I understand that except in dire emergencies all treatments and procedures will be discused with me prior to implementations. I agree to assume responsibility for all charges incurred in the care of my pet(s), as well as reasonable attorney's fees, court costs, and interest if the balance is sent for collection. **I understand that full payment is due at the time services are rendered, and that Advanced Veterinary Specialists does not bill for services or provide payment plans for treatment.** Payments must be made with cash, Visa, MasterCard, Discover, American Express, Care Credit or a Check pre-printed with your name and address. At least one picture identification (driver's license, etc) is required if you pay by check or credit card.

I acknowledge that I have read, understand and agree with the above information.

Signature: _____ **Date:** _____

Please bring all medications and any medical records you have for your pet(s) to their first visit.