SEQUOIA VETERINARY HOSPITAL, Inc.
INTERNAL MEDICINE REGISTRATION FORM

CLIENT INFORMATION

Updated Comp. ☐ Initials

Name		**Cell Phone**
E-Mail		**Home Phone**
Address		**Work Phone**
City	**Zip**	
Employer	**Occupation**	

Spouse or Co-owner		**Cell Phone**
E-Mail		**Work Phone**
Employer	**Occupation**	

PET INFORMATION

Pet's Name	***Circle one:***	Dog	Cat
Date of Birth		Male	Female
Breed		Intact	Neutered/Spayed
Color	**Microchip:**	Yes	No

Does your pet have any drug sensitivities or reactions?

Referring Dr. & Hospital

Regular Dr. if not the same as referring Dr.

Is your pet on any medications?

If yes, please list or provide records.

Dr. Jorgensen does not see general practice appointments. I understand and agree to continue to see a general practitioner for routine problems that do not relate to the problem for which my pet has been referred. _____ Initial

PAYMENT INFORMATION

Payment is due at the time professional services are rendered.

I assume responsibility for all charges incurred on this account, including but not limited to animal care, service charges, finance charges, and collection costs. _____ **Initial**

I understand that all charges will be paid at the time of release and that a deposit may be required. _____ **Initial**

I understand that any medical or surgical procedure is attended by risk and that it is not possible to guarantee the successful outcome of any such procedure. _____ **Initial**

I accept these terms and understand that this agreement is in force indefinitely from this date. _____ **Initial**

Method of Payment	Cash	Check(TeleChek)	MasterCard
	Debit Card	Care Credit	Visa

Signature of Owner or financially responsible party:	Signature	Date