



Cancer Veterinary Centers
BONITA SPRINGS | 3364 Woods Edge Circle, Bonita Springs, FL, 34134
NAPLES | 6530 Dudle Drive, Naples, FL, 34105
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Client Registration Form

Thank you for giving us the opportunity to care for your pet. So that we may become better acquainted, please complete the following information.

CLIENT INFORMATION

Date: ____/____/____
Last Name: _____ First Name: _____ Spouse/Co-Owner: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone Numbers: Home: _____ Work: _____ Cell: _____
Please check the primary contact number above
Email Address: _____ Employer and Address: _____

Were you referred to our office by a veterinarian? Yes No

If you were not referred to us by a veterinarian, whom may we thank for referring you? _____

What is the name and phone number of your *referring clinic*? _____ What is the name and phone number of your *primary clinic*? _____

What is the name of your *referring veterinarian*? _____

What is the name of your *primary veterinarian*? _____

Reason for today's visit? _____

PET INFORMATION

Name: _____ Species: Dog Cat Breed: _____
Color: _____ Date of Birth: ____/____/____ If unknown, approximate age: _____
Sex: Male Female Spayed/Neutered: Yes No
Is your pet up to date on vaccinations? Yes No How long have you owned your pet? _____

Is your pet currently on any medication? Yes No

If yes, please list medications and their dosages: _____

Please list any prior illnesses, surgeries, or allergies: _____

(Turn Over)

PAYMENT POLICY

We appreciate payment when services are rendered. This policy helps to control costs on which we base our fees. A 50% deposit is required on all cases and procedures.

Please indicate your choice of payment method: Cash Check Credit Card

Drivers License # _____ Exp Date _____

Note: A \$30 fee will be assessed for a returned check.

We will prepare a written estimate for services. We do not carry open accounts and hope the above alternatives are convenient for you.

FINANCIAL AGREEMENT AND AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, and treat my animal. I assume responsibility for all charges incurred in the care of my animal. I agree to pay any costs and charges necessary for the collection of any amount not paid when due. I am aware that CancerVets, in accordance with the American Medical Association's code of professional ethics, will provide only such emergency treatment as they deem necessary and that my pet and all its pertinent records will be sent back to the veterinarian that referred me as soon as practical.

I give CancerVets permission to share photos of my pet and the case progress made here at the practice on their website(s) and general social media for the purpose of bringing awareness to available treatment options and advances in medicine. (INITIAL: __) Yes No

We will gladly send you a notification if we use your photo so you can share it with friends and family.

X _____ Signature of Owner or Authorized Agent

X _____ Printed Name of Owner or Authorized Agent

_____ Today's Date