



MASH
METROPOLITAN ANIMAL
SPECIALTY HOSPITAL

Welcome!

Your pet's health is important to us.
Please take a few moments to fill out this form completely.
Thank you!

REGISTRATION

Owner(s): _____

Alternate Authorized Owner(s): _____

Address: _____

City: _____ Zip Code: _____

E-mail: _____ Owner Date of Birth: _____

Phone: _____ Alternative Phone: _____

Emergency Contact Name: _____ Phone: _____

How did you learn about our clinic? Sign Outside Yellow Pages Facebook Recommended
 Website News Paper Other: _____

If recommended, by whom? _____

PET HEALTH HISTORY

Name of Pet: _____ Dog Cat Other: _____

Breed: _____ Color: _____ Birthdate/Age: _____

Undetermined Male Neutered Female Spayed

Vaccines current? Yes No

Reason for visit: _____

Any other medical conditions? _____

Pet's current medications: _____

Describe your pet's diet: _____

Primary Veterinarian Name: _____

Hospital Name: _____ Phone: _____

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, and/or treat the above described pet. I assume full responsibility for all charges incurred for the care of this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for hospitalization or surgical treatment. I understand that it is the policy of MASH not to refund any medication that is prescribed by the veterinarian once it has left the hospital.

I grant to Metropolitan Animal Specialty Hospital (MASH), its representatives, and employees the right to take photographs of my pet. I authorize MASH, its assigns and transferees to copyright, use and publish the same in print and/or electronically. I agree that MASH may use such photographs of me or my pet with or without my name for any lawful purpose, including but not limited to such purposes as publicity, illustration, advertising, or web content.

Signature of Owner: _____ Date: _____