ANIMAL HOSPITAL
of the Rockaways

Thank you for choosing Animal Hospital of the Rockaways! We appreciate the opportunity to care for your pet(s). Please help us better meet your needs by taking a moment to complete this registration form.

Last Name: _____ First Name: _____ Spouse's Name: _____

Address: _____

Apt. #: _____ City: _____ Zip Code: _____+_____

Home Number: _____ Cell Number: _____

Email Address: _____

How did you hear about us (circle one)?

Internet Facebook Instagram Sign Yellow Pages The Wave Rockaway Times Other

If referred, who may we thank for referring you? _____

Tell us about your pet[s]...

Name	Species	Breed	Color	Sex	Spay/Neutered?	D.O.B

Did you bring medical records with you today? Y / N
Would you like to be paperless & receive communication via email? Y / N
Do you give authorization for photography of your animal while under our hospital's care? Y / N

I understand every effort will be made to achieve a successful outcome and to provide for all possible safety in hospital care and handling. I hereby authorize the Animal Hospital of the Rockaways to receive, prescribe, treat and/or perform surgery upon the pet[s] listed above and additional pets I present. I understand that a service fee may be assessed for each non-sufficient fund, check and/or certified letter that must be sent.

SIGNATURE: _____ **DATE: _____**

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