



CASTRO VALLEY COMPANION ANIMAL HOSPITAL

2509 Lessley Ave.
Castro Valley, CA 94546
510-582-6311
www.cvcah.com

CLIENT REGISTRATION FORM

Welcome to Companion Animal Hospital! Please take a moment to tell us about yourself!

Name _____

Last

First

MI

Address _____

Number

Street

City

Zip Code

Phone Numbers _____

Home

Work

Cell

Email _____

What is your preferred mode of contact? _____

Employer _____

Spouse _____

Alternate/Emergency Contact:

Name(s) _____ Relationship: _____

Cell # _____ Home # _____

Are contacts authorized to make medical decisions for pet(s)? YES NO

Do you currently have pet insurance? _____ If yes, what company? _____

How did you hear about our hospital? (Circle all that apply)

Google Search

Facebook

Twitter

Instagram

Yelp

Saw our sign/Drove by _____ Referred By: _____

May we use images of your pet on our website, social media, or on printed materials? _____

I understand that payment in FULL is due at the time services are rendered unless other arrangements have been made BEFOREHAND. For your convenience we accept cash, checks (with proper identification), Visa, MasterCard, American Express, Discover, and Care Credit. By signing below, I agree to pay the full amount at the time of my pet's discharge. A service charge equal to the legal rate of interest (18% annually) will be imposed on any outstanding balance. I fully understand that if I do not pay this account as agreed, any past due amounts are subject to costs of collection, including attorney fees.

If medications are prescribed by the doctor, you can let us provide it to you or you can choose to request a written prescription to be filled at the pharmacy of your choice.

Signed _____ (Owner/Agent) Date _____

Driver's License# (required for checks) _____ Date of Birth* _____

*Date of birth required by Drug Enforcement Agency (DEA) for prescribing controlled substances to your pet.

CVCAH Staff _____ Client ID# _____